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EDITOR'S NOTE

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o. 84-1809-CFX
tatus: GRANTED

ocketed:
ay 17, 1985

Title: Federal Trade Commission, Petitioner
v.
Indiana Federation of Dentists

Court: United States Court of Appeals
for the Seventh Circuit

Counsel for petitioner: Isenstadt,Ernest J., Tiffany,Marcy J.K.

Counsel for respondent: Fowler,Ronald K., Graham,Bruce W.

ntry	Date	Note	Proceedings and Orders
1	Mar 9 1985		Application for extension of time to file petition and order granting same until April 20, 1985 (Stevens, March 11, 1985).
2	Apr 10 1985		Application for extension of time to file petition and order granting same until May 20, 1985 (Stevens, April 11, 1985).
3	May 17 1985	G	Petition for writ of certiorari filed.
4	May 17 1985		Appendix of petitioner FTC filed.
6	Jun 14 1985		Order extending time to file response to petition until July 16, 1985.
7	Jul 15 1985		Brief of respondent IN Federation of Dentists in opposition filed.
8	Jul 17 1985		DISTRIBUTED. September 30, 1985
9	Aug 2 1985	X	Reply brief of petitioner FTC filed.
11	Oct 7 1985		REDISTRIBUTED. October 11, 1985
12	Oct 15 1985		Petition GRANTED.
			**********
13	Nov 8 1985		Record filed.
14	Nov 8 1985		Certified copy of original record & C.A. proceedings received.
16	Nov 25 1985		Order extending time to file brief of petitioner on the merits until December 6, 1985.
17	Dec 5 1985		Brief amicus curiae of Health Insurance Association of America filed.
18	Dec 6 1985		Joint appendix filed.
19	Dec 6 1985		Brief of petitioner FTC filed.
20	Dec 6 1985		Brief amicus curiae of Washington Business Group filed.
21	Dec 6 1985		Brief amicus curiae of American Assn. of Retired Persons filed.
23	Dec 23 1985		Order extending time to file brief of respondent on the merits until January 13, 1986.
24	Jan 13 1986		Brief amicus curiae of American Medical Association filed.
25	Jan 13 1986		Brief amicus curiae of American College of Radiology filed.
26	Jan 13 1986		Brief amicus curiae of Physicians and Surgeons of MA filed.
27	Jan 13 1986		Brief of respondent IN Federation of Dentists filed.
28	Jan 13 1986		Brief amicus curiae of American Dental Association filed.
29	Feb 4 1986		SET FOR ARGUMENT, Tuesday, March 25, 1986. (4th case)
30	Feb 4 1986		CIRCULATED.
31	Mar 18 1986	X	Reply brief of petitioner FTC filed.

o. 84-1809-CFX

ntry	Date	Note	Proceedings and Orders
32	Mar 25 1986		ARGUED.

PETITION FOR WRIT OF CERTIORARI

84-1809

No. 84-

Office Supreme Court, U.S.
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MAY 17 1985
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CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1984

FEDERAL TRADE COMMISSION, PETITIONER

v.

INDIANA FEDERATION OF DENTISTS

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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22 pp

QUESTION PRESENTED

Whether the court of appeals applied the proper standard of review in vacating a Federal Trade Commission order prohibiting a conspiracy by competing dentists to boycott insurance company cost containment programs where the majority concluded that the conspiracy was collective adherence to an established "legal, moral, and ethical" policy to promote "quality dental care."

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In the Supreme Court of the United States

OCTOBER TERM, 1984

No. 84-

FEDERAL TRADE COMMISSION, PETITIONER

v.

INDIANA FEDERATION OF DENTISTS

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

The Federal Trade Commission, pursuant to Section 16(a)(3) of the Federal Trade Commission Act, 15 U.S.C. 56(a)(3), petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.[1]

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[1] Section 16(a)(3) of the Federal Trade Commission Act, added to the Act by § 204(a) of the Magnuson-Moss Warranty-Federal Trade Commission Improvement Act, Pub. L. 93-637, 88 Stat. 2183, 2199 (1975), provides, *inter alia*, that where (as is the case here) the Commission has been represented in the court of appeals by its own attorneys, it may be represented in like manner before this Court if the Solicitor General, following timely request, declines to file a petition for certiorari. The Commission has chosen to exercise this authority, for the first time in its history, because it believes the decision below will have exceptionally serious adverse consequences for enforcement of the antitrust laws.

OPINIONS BELOW

The opinion of the court of appeals and the concurring opinion of Judge Fairchild (App. 1a-50a) are reported at 745 F.2d 1124. The order and opinion of the Federal Trade Commission (App. 54a-112a) and the initial decision of the administrative law judge (App. 118a-283a) are reported at 101 F.T.C. 57. The Commission's order denying Indiana Federation of Dentists' petition for reconsideration (App. 113a-117a) is reported at 101 F.T.C. 718.

JURISDICTION

The judgment of the court of appeals (App. 51a) was entered on October 11, 1984. A petition for rehearing was denied on December 21, 1984 (App. 52a-53a). The time within which to file a petition for a writ of certiorari has been extended to and including May 20, 1985. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES INVOLVED

Pertinent portions of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, are set forth at App. 284a-288a.

STATEMENT

1. This case involves a conspiracy by competing Indiana dentists to withhold from third-party payers x-rays sought for review under the cost containment provisions of industrial dental health care policies (App. 61a-62a). These industrial dental care policies, negotiated in collective bargaining between unions and employers, obligate the insurer to pay only for the reasonably necessary expenses of treatment (*id.* at 86a, 139a-140a). This condition is designed to help limit the costs of insurance (*ibid.*).

To determine employees' reimbursement, insurers must review the treatment dentists furnish or plan to furnish to insured patients (App. 3a, 61a n.4). Insurance companies[2] asked that dentists performing expensive dental procedures complete claim forms and forward them (preferably prior to treatment) with copies of existing dental x-rays and other relevant information as necessary (*ibid.*). Each claim was then examined by a lay-examiner, who could grant but not deny it, and if the claim was not granted, by a licensed dentist employed by the insurer (*id.* at 92a, 247a-248a).

The Indiana Dental Association ("IDA"), accounting for 85% of Indiana dentists, viewed cost containment programs as a threat to the economic welfare of dentists and as an unwarranted intrusion on the dentist-patient relationship (App. 5a, 78a-80a). It organized a collective refusal to forward x-rays to insurance companies for claims review (*id.* at 5a-6a) and had enlisted most of its members in the boycott by 1975 (*id.* at 5a-6a, 78a-80a).

Following this Court's decision in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), IDA's enthusiasm for the boycott flagged (App. 208a-209a). Concern over antitrust liability was a principal factor prompting certain IDA leaders to form the Indiana Federation of Dentists ("IFD") in 1976 (*id.* at 152a, 211a). IFD and its members continued the boycott,

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[2] This case involves dental insurance for, *inter alia*, employees of the International Harvester Company, then insured with Aetna Life and Casualty Company, General Motors Corporation, then insured with Connecticut General Life Insurance Company, and the Brockway Glass Company, then insured by Metropolitan Life Insurance Company (App. 6a-7a, 83a-84a).

under the misapprehension that their self-styled status as a "dentists union" would free them from "the antitrust albatros[s] around our neck" (*id.* at 213a).[3]

IFD's members adopted at their first annual meeting the "IFD Work Rule" binding member dentists not to submit x-rays to dental insurers (App. 22a, 82a-83a, 217a-218a). By requiring dentists to prevent a patient's condition from being evaluated "for any purpose" without a "complete examination," the Rule operated to preclude dentist cooperation with insurance claims review programs that relied upon x-ray submission (*id.* at 83a, 218a).

IFD members were active in and around three Indiana communities, Anderson, Lafayette, and Fort Wayne (App. 8a). Each of these towns was the site of a plant whose employees were insured under a dental health care plan (*id.* at 177a, 188a). IFD's efforts achieved widespread support, with a 95% membership rate in the Anderson-Madison County area and membership by "[a]ll but a few dentists" in the area covered by its Lafayette Chapter (*id.* at 84a-85a, 221a, 224a-225a).

The need for *collective* action by IDA and IFD dentists resulted from their recognition that "dentists who do not submit radiographs are hurt by the willingness of fellow dentists * * * who will intentionally do this to gain a patient" (App. 311a). Describing the spirit and purpose of the conspiracy, IFD's first

[3] IFD was organized to continue the IDA boycott (App. 71a, 215a-217a), and IFD's constitution and by-laws authorized it to engage in "strikes, job actions, boycotts, and other forms of economic pressure" (*id.* at 217a). IFD's first president explained to IDA's Board of Trustees that IFD's dentists had "found that via a union they could go beyond dental association activities" (*id.* at 215a).

president stated (*id.* at 49a-50a), "We are fighting an economic war where the very survival of our profession is at stake. * * * The name of the game is money."

In response to the IDA/IFD boycott, insurance companies were forced to modify their normal practices in processing insurance claims (App. 68a-69a). As a result, some claims were paid late or not at all (*ibid.*) and insurer efforts to contain costs by paying only for reasonable care were thwarted (*id.* at 83a).

2. In 1978 the Federal Trade Commission ("Commission") issued an administrative complaint against IFD, alleging that its boycott constituted, *inter alia*, an "unfair method of competition" under Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45 (App. 60a-62a).[4] Following an extensive administrative trial, an administrative law judge ("ALJ") entered an initial decision containing detailed findings to support his conclusion that the boycott was illegal *per se* and also had substantially injured competition under a rule of reason analysis (*id.* at 118a-291a).

On IFD's appeal from the initial decision, the Commission in a unanimous decision rejected a *per se* analysis of the boycott, but held that under the rule of reason IFD's purported legal, moral, and ethical justifications for its conduct were both unproven and insufficient to outweigh the boycott's anticompetitive effects. Explaining those anticompetitive effects the Commission stated:

> Such concerted activity by competitors resulted in reducing or eliminating competition among

[4] IDA was named a co-conspirator in the complaint but not a respondent because it had previously consented to entry of a cease and desist order prohibiting continuation of its boycott activities and repetition of similar conduct (App. 11a n.6).

dentists as to their policy of dealing with third-party payers. Patients who were covered by dental plans providing for cost-containment programs such as those here found it difficult to purchase care from dentists who would satisfy the terms of their coverage. In the absence of such concerted behavior, individual dentists would have been subject to market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third-party insurers. By colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate. Consequently, the dentist-insurer relationship was determined by economic coercion, not by market competition. The final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs.

* * * * *

IFD's concerted refusal to furnish x-rays to third-party payers substantially harmed competition among dentists by eliminating incentives for individual dentists to cooperate with cost-containment programs of third-party payers. This refusal to deal reduced consumer choice and impaired insurance companies' ability to conduct cost-containment programs. IFD has presented no evidence to even suggest that these restraints were necessary to serve any legitimate pro-competitive purpose.

App. 85a-86a, 95a-96a.

3. On IFD's petition for review of the Commission's decision, a panel of the Seventh Circuit held (Senior Judge Fairchild concurring in the result)

that the Commission had failed to establish under the rule of reason that the boycott had an anticompetitive effect (App. 2a). Repeatedly characterizing IFD's collective refusal to submit x-rays as the product of a "legal, moral, and ethical" policy to achieve "quality dental care," the majority opinion condemned as wholly conclusory the Commission's findings that dentists compete with one another in dealing with insurers and that this competition was harmed (*id.* at 38a-44a).

The court rejected as insufficient to establish anticompetitive effects evidence showing that most Indiana dentists had participated in the boycott through IDA and that 95% of all dentists in the Anderson area, and all but a few in the Lafayette area, had joined IFD and implemented its policies. The court likewise concluded that the additional cost and inconvenience of alternative procedures, found to be "prohibitively expensive" by the Commission (App. 88a), did not harm competition (*id.* at 42a-43a).

The majority opinion culminated in its assertion that the Commission's finding of an antitrust violation was a "rubber stamp approval of the group dental health care insurers' practices" (App. 44a). The majority complained that the Commission was, by challenging the boycott, "preventing dentists from joining together to promote standards of quality dental care" and, "with absolutely no training in the highly advanced field of dentistry" was "unwisely regulat[ing] the dental profession and all of its specialties, including endodontia, exodontia, oral surgery, orthodontia, pedodontia, periodontia, and prosthodontia, to the detriment of consumers" (*ibid.*). Although it identified no evidence to show that the boycotted cost containment programs had reduced the

quality of dental care, the majority stated that insurers "cannot be permitted to forsake standards of quality and proper dental care in an attempt to lower their dental costs" (*ibid.*).

Senior Judge Fairchild, who subsequently voted to grant rehearing by the panel, concurred initially in the result only because he concluded that evidence had not been developed on the competitive significance of dentists' non-cooperation with the insurers (App. 45a-50a). He expressly rejected the majority's repeated assertions that the concerted refusal to submit x-rays was based on "legal, moral, and ethical" considerations, accepting instead the Commission's summary of evidence showing that a substantial motivation for the boycott was economic (*id.* at 49a-50a).

The Commission's petition for rehearing was denied. Senior Judge Fairchild, as noted, voted to grant rehearing by the panel and Judges Cudahy, Eschbach, and Posner voted to grant rehearing *en banc* (App. 52a-53a).

REASONS FOR GRANTING THE PETITION

In *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 691, 696 (1978), this Court made clear that antitrust analysis of a conspiracy in restraint of trade is limited to its impact on competitive conditions, even where the challenged restraint is effected by professionals. With evident disapproval of both this principle and the Commission's statutory role in enforcing it, the court of appeals majority opinion uses the "substantial evidence" test to create a *de facto* exemption for group boycotts by professionals that purportedly further "legal, moral, and ethical" policy goals. The majority's ruling on the key subject of boycotts against insurers'

cost containment efforts distorts antitrust analysis to reflect the social and economic objectives of defendant health care providers rather than the procompetitive policy goals prescribed by Congress. The Court should grant certiorari to reverse this erosion of antitrust law protection for private sector cost containment initiatives in an area of increasing economic importance to consumers.

1. In concluding that the Commission lacked substantial evidence to support its conclusion that IFD's boycott injured competition, the court of appeals grossly misapplied the standards for judicial review of agency decisions, substituting its own beliefs about the market in question for uncontested and amply supported findings by the Commission.[6]

a. In condemning as "wholly conclusory" the Commission's finding that provision of x-rays to insurers was an element of competition among dentists, the court created an issue that IFD had not even raised before the Commission. With cost being a relevant consideration to many consumers in choosing health care, a dentist's willingness to cooperate with a dental insurer is of great importance. Refusal to cooperate can delay or foreclose the insurer's payment

[6] The Commission recognizes that the Court has placed principal responsibility for determining the substantiality of evidence on the record as a whole in the courts of appeals and " 'will intervene only in what ought to be the rare instance when the [substantial evidence] standard appears to have been misapprehended or grossly misapplied.' " *American Textile Mfrs. Inst.* v. *Donovan*, 452 U.S. 490, 523 (1981) (quoting *Universal Camera Corp.* v. *NLRB*, 340 U.S. 474, 491 (1951)). This case, however, presents that "rare instance" in which a gross misapplication of the substantial evidence standard also threatens a broader adverse impact upon antitrust law enforcement generally.

for contemplated treatments, and, thereby, delay or prevent the patient from obtaining needed care. Alternatively, if treatment has already been provided, the consumer may have to pay a greater sum out of pocket. Furnishing claims information to insurers is thus an integral part of the service offered by the dentist as an independent competing entrepreneur, *cf. Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332, 357 (1982), and many consumers will choose a dentist who cooperates with insurers in processing claims in preference to one who does not.

There was no doubt in the administrative proceeding that cooperation with insurers is an element of competition among dentists. That point was repeatedly acknowledged and conceded before the Commission by IFD, which observed in one brief that "dentists who are not members of [IFD], will naturally get favorable treatment from * * * employees with whom they may contract" (IFD Appeal Brief to Commission at 25) and in another that "[p]atients desirous of x-ray submission seek out complying dentists" (IFD Reply Brief to Commission at 5). The State of Indiana, which intervened before the Commission on behalf of IFD, also acknowledged that "[a]ssuming * * * a percentage of dentists in a particular area do not submit insurance x-rays, it is only reasonable, and foreseeable, that the remaining dentists who do supply x-rays will have a competitive edge when seeking insurance related business" (State of Indiana's Brief Before ALJ at 6.)

Moreover, abundant record evidence supports what all parties save the court of appeals took as a given. Conspirators' documents of record (App. 289a-314a) detail the competitive consequence of a dentist's refusal to cooperate with insurers. For example, a dental society newsletter published early in the "no x-ray" conspiracy complained that some Indiana dentists were ignoring the boycott and submitting x-rays "in an attempt to gain economic advantage over their peers" (*id.* at 289a). These dentists were accused of an "unethical practice [that] puts increasing pressure of a monetary nature" on their competitors (*ibid.*, see also *id.* at 293a).

The competitive effect, gaining or losing patients, that would result from a dentist's attitude toward insurer cooperation, was also acknowledged in dental society documents discussing the problem posed in border areas, where "[Indiana] dentists who do not submit radiographs are hurt by the willingness of fellow dentists in urban Louisville in Kentucky who will intentionally do this to gain a patient" (App. 307a, see also *id.* at 300a, 311a). The same obvious fact was recognized by oral surgeons who jointly wrote their local IDA component society to protest the "unethical" behavior of a competing practitioner who was gaining business by submitting x-rays to insurers (*id.* at 182a n.47, 313a-314a).

The concessions of IFD and the record evidence were those that " 'a reasonable mind might accept as adequate to support a conclusion,' " *Consolo* v. *Federal Maritime Comm'n*, 383 U.S. 607, 620 (1966) (quoting *Consolidated Edison Co.* v. *NLRB*, 305 U.S. 197, 229 (1938)), and the reviewing court's finding of an evidentiary deficiency that the petitioner did not even raise with the Commission is a gross misapplication of the standards for judicial review of agency decisions. See *United States* v. *L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 37 (1952).

b. Equally heedless of the standards for appellate review is the court's apparent conclusion that the

Commission failed to show substantial evidence that the boycott exerted an anticompetitive effect.

The boycott's effectiveness is demonstrated by the scope it achieved while shepherded by the state-wide IDA, most of whose members joined in (p. 3, *supra*), and by IFD's subsequent success. Focusing on selected counties, IFD achieved 95% participation in the Anderson-Madison County area and, according to its Lafayette chapter, almost total participation by competing dentists in that region (p. 4, *supra*). Moreover, as IFD intended, its boycott shut off the flow of x-rays and coercively increased insurer costs by precluding meaningful claims review absent expensive in-office and in-mouth examination (App. 68a-69a).

Notwithstanding this record evidence that the boycott had its intended economic effect, the majority insisted that this demonstration of market power showed no alteration of the relevant market to harm competition among dentists, but only effects sufficient to warrant investigation (App. at 39a-40a). This patent reweighing of evidence contravenes established standards of review, *e.g.*, *Steadman* v. *SEC*, 450 U.S. 91, 99 (1981), as well as current antitrust law rendering elaborate analysis unnecessary when businessmen agree to restrict output, *National Society of Professional Engineers* v. *United States*, 435 U.S. at 692; *NCAA* v. *Board of Regents of Univ. of Okla.*, 104 S.Ct. 2948, 2960 (1984).

c. The court of appeals majority also took impermissible liberties with the record in concluding that IFD's boycott was nothing more than collective adherence to an established "legal, moral, and ethical" policy to promote "quality dental care." The evidence showed that the dentists were fighting what IFD's first president called "an economic war" in

which "[t]he name of the game is money" (App. 49a-50a). The Commission found IFD's contention that its boycott was necessary to promote public health and safety and ensure quality dental care unsupported, as there was no indication that any consumer had suffered substandard dental care or any other injury as a result of insurer use of x-rays to review claims (*id.* at 91a-92a, 240a-241a). The Commission also found that there were no legal barriers in state law prohibiting health care providers, such as dentists, from furnishing third-party payers with patient information (*id.* at 100a-101a).

Despite the absence of record evidence to establish a "legal, moral, and ethical" justification for the boycott, or that the position adopted by the conspirators merely reflected "established, accepted, and approved standards of quality dental care," the majority invoked these phrases (more than 20 times in its opinion) as though they were established fact.[7] It characterized the group boycott as nothing more than the "dentists' concerted effort to ensure quality dental care" (App. 29a), and described the issue in the case variously as whether IFD engaged in a group boycott by collectively "adhering to a policy that complies

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[7] The majority erroneously assumed that insurers who requested x-rays were violating established standards of care by formulating "a course of dental treatment * * * based solely upon an insurance claim form and copies of a patient's dental x-rays" (App. 29a). In fact, insurers merely determine how much they will pay; the dentist and patient alone decide what treatment the patient will undergo. The implication of the panel's holding is that every time a third-party payer denies or reduces a claim it improperly intervenes in the dentist's professional decisionmaking. Moreover, the Commission found that the insurers sought x-rays "to use them along with other information to review claims" (*id.* at 90a).

with the established, accepted and approved standards of quality dental care" (*id.* at 24a) and whether substantial evidence supported the Commission's finding that "the dentists' adherence to a legal, moral, and ethical policy of quality and proper dental care * * * had an anticompetitive effect" (*id.* at 37a). As with its disregard of evidence supporting the Commission's findings of anticompetitive effect, the court's reweighing of evidence to bolster its roseate view of an antitrust conspiracy by learned professionals was a gross abuse of the substantial evidence standard of review.

2. The court of appeals' decision threatens harmful consequences for antitrust law enforcement far beyond its condonation of an unlawful conspiracy by the dentists of one state. The court's repeated talismanic references to the assumed "legal, moral, and ethical" goal of the conspirators to provide "quality dental care" suggest that its real concern in this case was not with the state of the record but with the state of the law that forbids restraints of trade by professionals even when supposedly motivated by lofty purpose, *National Society of Professional Engineers* v. *United States*, 435 U.S. at 691, 696.[8] Indeed, the majority opinion manifests antipathy to the government even questioning dentists' conduct and to vigorous cost containment efforts by insurers (App. 44a).

The court's rejection of the Commission's efforts to enforce the law against the antitrust conspiracy in this case, however rationalized by claims of eviden-

[8] For other instances of lower court aversion to applying *National Society of Professional Engineers* to anticompetitive boycotts by professionals see generally Kissam, *Antitrust Boycott Doctrine*, 69 Iowa Law. Rev. 1165, 1210-23 (1984).

tiary insufficiency, cannot help but embolden other professional groups to believe they may attempt similar conduct, appealing to reviewing courts' sympathy for their asserted extralegal purposes if challenged.

The court's encouragement to unlawful conduct occurs in an area in which antitrust enforcement has become increasingly important. By 1983, health care expenditures had escalated to 10.8% of gross national product, up from 7.5% in 1970.[9] Private sector initiatives, such as the cost containment programs thwarted by IFD in this case, are at the forefront of the battle against escalating health care costs.[10]

By 1978, dental insurance, primarily multi-state group health insurance plans underwritten by corporate employers, covered 48 million people (App. 139a n.22). In the early 1970s, employers began insisting that insurers implement cost containment features to provide reimbursement for adequate (although not the most expensive) dental treatment options (*id.* at 138a-142a). Pressure by the indirect purchasers, *i.e.*, employers and insurers, to limit health care bills has introduced stronger competitive forces into the health care market.[11] Preservation of competition in the

[9] Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, 6 Health Care Financing Rev. 1 (Winter 1984).

[10] See, *e.g.*, Council on Wage and Price Stability, *Employee Health Care Benefits, Labor and Management Sponsored Innovations in Controlling Costs*, 41 Fed. Reg. 40298, 40303-05 (1976).

[11] See, *e.g.*, *Kartell* v. *Blue Shield of Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 53 U.S.L.W. 3740 (U.S. Apr. 15, 1985); *Ball Memorial Hosp., Inc.* v. *Mutual Hosp. Ins., Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 66,463 (S.D. Ind. Mar. 1, 1985), *appeal docketed*, No. 85-1481 (7th Cir. Mar. 25, 1985).

health care market so that private sector cost containment initiatives may work is, therefore, of vital importance to the economy.

The relationships between health care providers and third-party payers are particularly conducive to boycotts by providers aimed at cost containment efforts.[12] Conspiracies akin to the one here have flickered regularly in local markets around the country until doused by consent decree or other federal or state enforcement action.[13] Only two federal cases have been carried to the courts of appeals in a decade of careful monitoring by the Commission and the Antitrust Division—this one, and *American Medical Ass'n* v. *FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982). Now a gap has opened in the common law of competition previously accepted by court, counsel, and provider organizations. It threatens a new and wider flare-up of anticompetitive methods for resisting cost containment unless corrective action is taken by the Court.

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[12] See, *e.g.*, Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J., 303, 313, 317-318, 344 (1978).

[13] *E.g.*, *United States* v. *South Carolina Health Care Ass'n*, 1980-2 Trade Cas. (CCH) ¶ 63,316 (D.S.C. 1980) (consent decree); *Michigan State Medical Society*, 101 F.T.C. 191 (1983) (litigated cease-and-desist order); *New York* v. *New York State Society of Ophthalmic Dispensers, Inc.*, 1980-1 Trade Cas. (CCH) ¶ 63,074 (N.Y. Sup. Ct. 1979) (consent decree); *Indiana Dental Ass'n.* 93 F.T.C. 392 (1979) (consent order against the same practices involved here); *Texas Dental Ass'n*, 100 F.T.C. 536 (1982) (consent order against practices similar to those involved here); *Association of Independent Dentists*, 100 F.T.C. 518 (1982) (consent order); *United States* v. *Montana Nursing Home Ass'n, Inc.*, 1982-2 Trade Cas. (CCH) ¶ 64,852 (D. Mont. 1982) (consent decree).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

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In the Supreme Court of the United States

OCTOBER TERM, 1984

FEDERAL TRADE COMMISSION, PETITIONER

v.

INDIANA FEDERATION OF DENTISTS

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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[OPINION AND ORDER]

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 83-1700

INDIANA FEDERATION OF DENTISTS,
an unincorporated association, PETITIONER,

v.

FEDERAL TRADE COMMISSION, RESPONDENT.

Petition for Review of an Order of the
Federal Trade Commission.

ARGUED FEBRUARY 9, 1984—
DECIDED OCTOBER 11, 1984

Before PELL and COFFEY, *Circuit Judges*, and FAIRCHILD, *Senior Circuit Judge*.

COFFEY, *Circuit Judge*. The Indiana Federation of Dentists ("IFD") petitions this court to review an order of the Federal Trade Commission ("Commission") requiring the IFD and its member dentists to "cease and desist from engaging" in a collective refusal to comply with the group dental health care insurers' directive to submit copies of a patient's

dental radiographs along with the patient's insurance claim form. We conclude that under a rule of reason analysis, the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market. Accordingly, we vacate the Commission's "cease and desist" order.

I

The parties admit that the controversy in this case arises from the two alleged cost-containment provisions that insurance companies include within their group dental health care plans.[1] These provisions are entitled "predetermination of claims" and "least expensive adequate course of treatment." According to the former plan, the dentist and patient may, at their discretion, submit a proposed course of dental treatment to the insurer for review. The insurer, in turn, will provide the dentist and patient with an estimate of the insurance benefits to be paid for the proposed treatment. The "least expensive adequate course of treatment" plan provides that for all courses of dental treatment, whether proposed or completed, the group dental health care insurer will pay benefits only for the least expensive treatment that is "commonly accepted as providing good dental care." *Indiana Federation of Dentists*, 101 F.T.C. 57, 159 n.4 (1983).

[1] The record reveals that group dental health care plans originated in Indiana in the early 1970's. These plans were, at the time of this lawsuit, included in collective bargaining agreements for the benefit of union-member employees. Neither the ALJ nor the Commission found that the alleged cost-containment provisions included within these plans actually lowered the insurers' dental costs.

In an effort to enforce these alleged cost-containment provisions, the group dental health care insurers direct dentists to submit copies of a patient's dental radiographs ("x-rays") along with the patient's insurance claim form. The claim form and x-rays, if submitted, are initially reviewed by lay personnel employed by the insurance company.[2] These lay employees have the authority to approve the proposed or completed course of dental treatment. If an insurer's lay employee questions a particular course of treatment, the claim form and x-rays are transmitted to a licensed dentist, selected and hired by the insurer to review dental claims. Based upon an analysis of the claim form and x-rays alone, without a patient case history much less a complete dental examination, the insurer's employed dentist determines the least expensive type of treatment that will, from the insurer's standpoint, provide "good dental care."

The instant case concerns the practice of the 84 current and 8 former IFD member dentists who collectively refused to comply with the group dental health care insurers' directive to submit copies of a patient's dental x-rays along with the patient's insurance claim form. The IFD maintains that "[p]roper diagnosis and treatment planning predicates the doctor correlating *all* diagnostic aids, with a history and with all clinical findings." *Id.* at 119, 129 (emphasis added). In accord with this policy of quality and proper dental care, the IFD member dentists "provide all diagnostic aids [including x-rays] to third parties on an in-office basis and with the con-

[2] The lay personnel employed by the group dental health insurers to review a patient's claim form and dental x-rays are not licensed to practice dentistry within the State of Indiana, and thus have no formal dental or radiological training.

sent of the patient." *Id.* at 121-22.[3] Furthermore, it is the IFD policy that the insurers' employed dentists conduct this examination and review of all diagnostic and clinical aids used in formulating a proper course of dental treatment. Pursuant to Indiana law, "[a]ny person . . . who . . . offers to diagnose or professes to diagnose . . . any of the lesions or diseases of the human oral cavity, teeth, gums, maxillary or mandibular structures" is practicing dentistry and must be licensed. Ind. Code §§ 25-14-1-1, 25-14-1-23 (1982). The IFD asserts that the unlicensed lay personnel employed by group dental health care insurers to review claims engage in the unlawful practice of dentistry when they examine and "diagnose" dental x-rays for purposes of benefit determination. Thus, the IFD concludes that the submission of dental x-rays to unlicensed lay personnel for diagnostic procedures is aiding and abetting the unlicensed practice of dentistry in violation of Indiana state law.[4]

---

[3] The group dental health care insurers are commonly referred to as "third parties" or "third party payers." *See Indiana Federation of Dentists,* 101 F.T.C. at 57, 61.

[4] The Indiana state legislature created the Board of Dental Examiners to administer and enforce the "laws pertaining to the practice of dentistry and of dental hygiene." Ind. Code § 25-14-1-13(a) (1982). In furtherance of this duty, the Board is required to "adopt a code of professional conduct and . . . adopt rules and regulations establishing standards for the competent practice of dentistry or dental hygiene." *Id.* In April 1982, some three and one-half years after the Commission filed its complaint in the instant case, the Board enacted new regulations governing the competent practice of dentistry within the State. According to the Board, "[a]ny person using dental diagnostic materials [including dental radiographs, *see* 828 Ind. Adm. Code 1-4-1(3)] for the purpose of recommending changes in the treatment plan upon which

According to the findings of fact of the Administrative Law Judge ("ALJ"), as adopted by the Commission, there were 3,100 licensed dentists practicing within the State of Indiana in 1974 and 85-88 percent of those dentists belonged to the Indiana Dental Association ("IDA"). The IDA had an official "Manual on Group Funded Dental Care Programs" ("Manual") recommending the procedures that member dentists follow when treating patients covered by a group dental health care insurance plan. The Manual included a section entitled "I.D.A. Policy Regarding Group Dental Care," providing in pertinent part:

> "The method of authorization of dental health care under pre-payment plans should be limited to determining the eligibility of the patient and extent of liability of the plan and should prevent any interference with the dentist-patient relationship or with the judgment and decision of the dentist. The plan must not *require* the dentist to submit radiographs (x-rays) to a third party.

Indiana Federation of Dentists, 101 F.T.C. at 83 (emphasis original) (footnote omitted). The Manual also contained a form letter, entitled "To All My Patients," that provided in pertinent part:

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benefits are based is practicing dentistry and must be a dentist." 828 Ind. Adm. Code 1-4-2 (1984). Furthermore, the Board provides that "Indiana dentists shall not knowingly submit dental diagnostic materials to any party involved in the Unauthorized Practice of Dentistry." 828 Ind. Adm. Code 1-4-3. The IFD contends that unlicensed lay personnel do, in fact, examine dental x-rays and recommend changes in dental treatment when they question a course of dental treatment. Accordingly, the IFD claims that submission of a patient's dental x-rays to unlicensed lay personnel for diagnostic procedures is in violation of the Indiana state law as established in 828 Ind. Adm. Code 1-4-3.

"Dental radiographs (x-rays) are a part of the dentist's legal health records. They are available for valid review by a qualified representative(s) of your insurance company in this office. Radiographs (x-rays) will not be submitted to third parties for their use in determination of benefits (e.g., least expensive adequate procedure, or optional course of treatment) because a determination of an adequate treatment plan can only be made after a knowledge of the following:

A. Complete patient evaluation.

B. Radiographs.

C. Additional diagnostic procedures as required."

Id. at 83, 162-63. In addition to formulating these guidelines for member dentists, the IDA undertook a pledge project in 1973 to obtain written pledges from their members that they would not participate in group funded dental health care plans unless such plans were previously approved by the IDA. It was the IDA's position that "proper dental treatment is predicated on a diagnosis from many types of examination and not radiographs alone." *Id.* at 90. According to the IDA statistics, approximately 85 percent of the member dentists agreed to support the IDA policy.

The ALJ found that the "smaller insurers had generally gone along with the Indiana dentists' demands" to not *require* the submission of dental x-rays alone, but to review all diagnostic aids in determining a proper course of dental treatment. The ALJ further found that in July 1971, Aetna Life and Casualty Insurance Co. ("Aetna") insisted that Indiana dentists submit copies of dental x-rays for patients covered under Aetna's group dental plan with International Harvester and the United Auto Workers. Only a "small percentage of dentists" in the Allen County-Fort Wayne, Indiana area complied with Aetna's directive. By mid-1972, some 600 unpaid dental claims had accumulated and "[i]t was the consensus of Harvester, U.A.W. and Aetna that many of these 600 claims were probably meritorious and that they had to be taken care of in some way." *Id.* at 98, 172. Accordingly, Aetna selected and retained a dentist and "arranged for him to go to the office of each dentist concerned and work with the relevant x-rays and any other diagnostic aids in the dentist's files." *Id.* The ALJ found that "[t]his *modus operandi*, of course, came quite close to meeting IDA's unrealistic terms for insurer access to x-rays: 'qualified' personnel to come to the treating dentist's office." *Id.*

Similarly, in October 1974, Connecticut General Life Insurance Company, ("Connecticut General") required that Indiana dentists submit copies of dental x-rays for patients covered under Connecticut General's group dental plan with General Motors and the United Auto Workers. The IDA member dentists objected to Connecticut General's policy and eventually the parties entered into a "gentlemen's agreement" whereby the IDA member dentists were merely asked to submit copies of a patient's dental x-rays but were not required to do so. Nonetheless, the ALJ found that by the spring of 1976, Connecticut General was receiving about 70 percent of its needed x-rays except in the Madison County-Anderson, Indiana area where only "about 2 to 4 out of 40 dentists—would ever submit x-rays when requested" by Connecticut General. *Id.* at 109, 172.

In August 1976, the petitioner, IFD, was formed as a separate and distinct association of Indiana

dentists.[5] The IFD's constitution and by-laws provided that:

> "The Indiana Federation shall represent, protect, maintain, and advance, through activities accomplished by relevant techniques which may lawfully be engaged in by a labor organization, the interests of the dentists within its jurisdiction. The objectives of this Federation shall include, but not be limited to the following:
>
> a.) To represent dentists in all socio-economic matters, negotiations and grievances with employers, third, and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public."

Id. at 74-75, 118, 171. As of February 1979, the IFD had 84 current and 8 former members concentrated within the localities of its three chapters: Anderson, Indiana and surrounding Madison County (46 members); Ft. Wayne, Indiana and surrounding Allen County (19 members); and Lafayette, Indiana and the surrounding counties of Carrol, Clinton, Tippecanoe, and White (27 members). Two of the dentists largely responsible for organizing the IFD, Dr. David McClure of Anderson, Indiana and Dr. Dan Rohn of Anderson, Indiana, had served on the Council of Dental Care Programs for the IDA formulating "policies, standards and principles for evaluating group-

[5] According to the ALJ's findings of fact, as adopted by the Commission, the IFD was organized as a labor union in an attempt to qualify for exemption from the Federal antitrust laws under the Clayton Act § 6, 15 U.S.C. § 17.

funded dental care programs," and in that capacity had co-chaired the IDA's pledge project.

In April 1977, the IFD member dentists adopted a "work rule" setting forth the IFD's policy that a proper dental diagnosis and treatment planning requires a review of all diagnostic and clinical aids, not simply a review of the patient's x-rays and insurance claim form. According to the IFD:

> "Proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids, with a history and with all clinical findings. *No one facet of this process is now, or ever has been recognized by the profession as a substitute for the complete process.* To represent otherwise would subject the patient to substandard care.
>
> The patient's dentist, therefore, has a moral and legal responsibility to not allow a determination of his patient's condition to be made for any purpose, without the benefit of a complete examination which takes into account all of the elements described."

Id. at 119, 129, 176 (emphasis added). Additionally, the IFD drafted a form letter for its members use when replying to a group dental health care insurer's request to submit copies of a patient's dental x-rays along with the patient's insurance claim form. The letter provided:

> "Reference your request for x-rays for the above named patient. It is the policy of this office to provide all diagnostic aids to third parties on an in-office basis and with the consent of the patient. It is my belief that proper diagnosis and treatment planning predicates the doctor

correlating all diagnostic aids with a history and all clinical findings. *No one facet of this process is now, or ever has been, recognized by the profession as a substitute for the complete process.* To represent otherwise would subject the patient to substandard care.

If you will have your consultant contact my office to set up an appointment, I will furnish records and ask the patient to be present for an examination. If you do not feel that this is possible, the Indiana Federation of Dentists, of which I am a member, will help you, if possible, to provide a local consultant."

Id. at 122 (emphasis added).

The ALJ found that in January 1977, Connecticut General breached its "gentlemen's agreement" with the IDA and instituted a practice of insisting that Indiana dentists submit copies of a patient's dental x-rays along with the patient's insurance claim form. Dr. Rohn and other officers of the IFD immediately confronted the Connecticut General management to voice their disapproval over this change in policy. Following this meeting, Connecticut General "refrained from making any further requests for x-rays from Madison County (the Anderson area) for fear of a confrontation which would end all existing cooperation and snarl the payment of GM workers' claims." *Id.* at 123, 172. The ALJ further found that between April 1976 and January 1978, Metropolitan Life Insurance Co. of New York ("Metropolitan"), the group dental health insurer for the 450-500 employees of Brockway Glass in Madison County, directed Indiana dentists to submit copies of their patient's dental x-rays for benefit determination. The IFD member dentists refused to comply

with this directive, and according to the ALJ, "Metropolitan simply declined to pay on claims when x-ray requests were refused." *Id.* at 123. In response, the personnel manager of Brockway Glass and the local union president "made efforts to talk IFD's Dr. McClure into submitting x-rays but were unsuccessful." *Id.* at 123-24, 172-73.

In October 1978, the Commission issued a complaint against the IFD, charging it with a violation of the Federal Trade Commission Act § 5, 15 U.S.C. § 45(a)(1), which provides that "[u]nfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are declared unlawful."[6] The complaint al-

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[6] The record reveals that the IDA was named as a co-conspirator in the Commission's complaint but not as a respondent because in November 1978, the Commission and the IDA entered into a consent decree that provides in pertinent part:

> *"It is further ordered,* That respondents . . . shall cease and desist from engaging in any activity, course of conduct, practice, or policy that in whole or in part:
>
> A. Requests, urges, recommends or suggests that dentists, or has the purpose or effect of requiring or organizing dentists to, (1) refuse to submit radiographs or such other pre-treatment and post-treatment reports, analyses and materials (except where post-treatment radiographs are not taken in the course of treatment and would expose the patient to unnecessary radiation) as third-party payers request for use in benefit determination or (2) refuse to deal in any particular way with any one or more third-party payers."

Indiana Dental Association, 93 F.T.C. 392, 398 (1979); 43 Fed. Reg. 53,768 (1978). *Accord Texas Dental Association*, 100 F.T.C. 536, 540 (1982).

leged that the IFD and its members had "engaged in acts, practices, and methods of competition to eliminate, prevent, or hinder competition among dentists with respect to cooperation by dentists with dental health care benefits programs containing predetermination and least expensive adequate course of treatment provisions." *Id.* at 59, 165-66. Specifically, the Commission alleged that the IFD was:

> "Promulgating, adopting, publishing, and distributing to its members a purported 'work rule' that details certain uniform courses of conduct for dentists in their dealings with third party payers; and
>
> Urging payers, purchasers and beneficiaries of dental health care benefits plans to eliminate provisions of such plans that [the IFD] finds unacceptable."

Id. at 61. The complaint further alleged that the IFD's practice had the following effects:

> "A. Competition among dentists in Indiana has been hindered, restrained, foreclosed, and frustrated;
>
> B. The cost of dental health care services in Indiana has been or may be stabilized, fixed, or otherwise tampered with;
>
> C. Consumers have been or may be deprived of the benefit of third-party payers' cost-containing measures, including lower or potentially lower costs for dental health care services and dental health care benefits insurance;
>
> D. Consumers have been or may be denied the benefits of a second dentist's opinion as to the adequacy of proposed dental treatment; and

> E. Consumers have been limited in their opportunity to select dentists who cooperate with dental health care benefits programs."

Id. at 62.

Following an administrative hearing in October 1979, the ALJ issued a 132 page "Initial Decision" in March 1980. The ALJ found that "the members of IFD stand committed to a concerted refusal to furnish their patients' x-rays to dental health insurers. . . . [T]here is abundant evidence that IFD has actually carried out the IDA/IFD boycott scheme as planned." *Id.* at 121, 153.[7] According to the ALJ,

---

[7] The ALJ made the following preliminary rulings:

(1) The IFD's alleged anticompetitive activity had a "substantial effect upon interstate commerce" and thus the Commission had jurisdiction over the complaint pursuant to 15 U.S.C. § 45(a)(1), *Indiana Federation of Dentists*, 101 F.T.C. at 77-78, 153 (on appeal the Commission affirmed this decision, *see* 101 F.T.C. at 161-64);

(2) The IFD was organized to "carry on business in substantial part for the profit of its members" and thus was a corporation for purposes of the Federal Trade Commission Act § 4, 15 U.S.C. § 44, subject to the Commission's jurisdiction, *Id.* at 75-76, 153, 160;

(3) The "IFD is not and never has been a labor union within the meaning of section 6 and 20 of the Clayton Act," 15 U.S.C. § 17, and thus did not satisfy the labor union exemption from the Federal antitrust laws, *Id.* at 76, 153, 160; and

(4) The McCarran-Ferguson Act, 15 U.S.C. §§ 1012, 1013(b), which exempts the practice of insurance from Federal antitrust laws did not apply in the instant case because the IFD did not engage in the business of insurance and even though the illegality concerned the insurance industry, the McCarran-Ferguson exemption does not apply to boycotts, *Id.*

The IFD does not appeal any of these decisions.

this group boycott began with the IDA and "it was primarily consciousness of the antitrust risk inherent in IDA's organized boycott of Indiana's dental health care insurers—much magnified by the Supreme Court's 1975 ruling in *Goldfarb* [*v. Virginia State Bar*, 421 U.S. 773 (1975)]—which led to the organization . . . of IFD . . . ." *Indiana Federation of Dentists*, 101 F.T.C. at 115. The ALJ ruled that the IFD "was formed in 1976 to join and continue a concerted refusal by many dentists in Indiana to submit radiographs (x-rays) to dental health insurers either automatically or on request." *Id.* at 153, 160. The ALJ concluded that the IFD's participation in this concerted refusal constituted a group boycott and was a *per se* violation of the Federal antitrust laws.[8] The

[8] According to the Supreme Court in *National Soc. of Professional Engineers v. United States*, 435 U.S. 679 (1978), there are two categories of antitrust analysis:

> "In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality—they are 'illegal *per se*.' In the second category are agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was impoeed."

435 U.S. at 692. The *per se* analysis in Federal antitrust law applies to certain types of group boycotts. *See, e.g., Klor's v. Broadway-Hale Stores*, 359 U.S. 207 (1959) (retailers combined with appliance manufacturers and distributors to boycott competing retailer); *Fashion Originators' Guild v. F.T.C.*, 312 U.S. 457 (1941) (organization of dress manufacturers and fabric designers boycotted retailers and manufacturers who dealt in copies of originals or refused to promise not to deal in such copies). According to the settled law in this circuit, "the common attribute of *per se* illegal group boycotts is 'a concerted attempt by a group of competitors at

ALJ added, in the alternative, that if such activity was not a *per se* violation, the record did not establish that the "effect on health/safety . . . outweigh[ed] the plainly anticompetitive and anti-consumer effects of the IDA/IFD group boycott of dental health care insurers," and thus the activity was also violative of

one level to protect itself from competition from non-group members who seek to compete at that level.'" *U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d 781, 788 (7th Cir. 1981) (en banc) (quoting *Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1178 (D.C. Cir. 1978)). More recently, this court has stated that group boycotts are illegal *per se* only if they are used to enforce agreements that are themselves illegal *per se*. *See Car Carriers, Inc. v. Ford Motor Co.*, No. 83-1825 slip op. at 11 (7th Cir. October 2, 1984); *Vogel v. American Society of Appraisers*, No. 83-3218 slip op. at 3 (7th Cir. September 20, 1984). We note, however, that the foundation for this statement initially appeared in *Marrese v. Am. Academy of Orthopaedic Surgeons*, 706 F.2d 1488, 1493 (7th Cir. 1983), a case that was subsequently vacated by this court, and later appeared in *Wilk v. American Medical Ass'n*, 719 F.2d 207, 221 (7th Cir. 1983), a case that relied solely upon the vacated *Marrese* opinion.

Once *per se* illegality is established, there is a conclusive presumption that the conduct is unreasonable in violation of the Federal antitrust laws. *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 344 (1982); *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 50 (1977); *Northern Pac. R. Co. v. United States*, 356 U.S. 1, 5 (1958). If, however, the defendants' concerted conduct is "not designed to drive out competitors, but to achieve some other goals," *U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d at 788, the court must engage in a rule of reason analysis. In this circuit "[i]t is necessary under the rule of reason to show anticompetitive effects, or actual harm to competition, to establish an antitrust violation . . . ." *Bunker Ramo Corp. v. United Business Forms, Inc.*, 713 F.2d 1272, 1283 (7th Cir. 1983); *Havoco of America, Ltd. v. Shell Oil Co.*, 626 F.2d 549, 556 (7th Cir. 1980).

the Federal antitrust laws under a rule of reason analysis. *Id.* at 153, 166.

Additionally, the IFD argued at the administrative hearing that its practice was "clearly articulated and affirmatively expressed as [Indiana] state policy," "actively supervised" by the state, and thus exempt from the Federal antitrust laws under the doctrine of state action. *See, e.g., California Liquor Dealers v. Midcal Aluminum*, 445 U.S. 97, 105 (1980). According to the IFD, its refusal to submit copies of a patient's dental x-rays to lay personnel employed by the group dental health care insurers was in compliance with Indiana state law which prohibits aiding and abetting the unlicensed practice of dentistry.[9] The ALJ equivocated on this issue, initially ruling that "there is probably no violation of the law against unlicensed practice of dentistry" when unlicensed lay personnel simply review claims for approval and have no authority to deny such claims in full or in part. *Indiana Federation of Dentists*, 101 F.T.C. at 137. The ALJ further ruled that even if the unlicensed lay personnel are engaged in the unlawful practice of dentistry, the Indiana law does not permit dentists "to organize a group boycott to help enforce the law." *Id.*[10]

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[9] Pursuant to Ind. Code § 25-14-1-23, the practice of dentistry includes:

> "Any person . . . who . . . offers to diagnose or professes to diagnose or treats or professes to treat any of the lesions or diseases of the human oral cavity, teeth, gums, maxillary or mandibular structures . . . ."

[10] The record reveals that the State of Indiana was granted leave to intervene in this lawsuit in July 1979 by the United States District Court for the Southern District of Indiana. The district court found that:

The IFD appealed the ALJ's "Initial Decision" and in February 1983, the Commission issued a "Final Order." The Commission adopted the ALJ's findings of fact, agreed with the ALJ's determination that the IFD member dentists had engaged in a "group boycott," but rejected the ALJ's conclusion that such conduct was a *per se* violation of the Federal antitrust laws. The Commission reasoned that a *per se* analysis of this case was improper because the IFD member dentists' refusal to comply with the insurers' x-ray directive was not "wholly motivated by an anticompetitive purpose" nor was it "aimed principally at excluding competitors." *Id.* at 168.[11] Thus, the Commission analyzed the IFD member dentists' conduct under a rule of reason, finding that:

> "The State of Indiana has and is, actively regulating both dentists and the practice of dentistry within the State. . . . Under the mandate of Indiana law, Indiana dentists are prohibited from submitting their dental x-rays to third party insurers who employ 'dental consultants,' who are not licensed to practice dentistry, to read or diagnois [sic] the x-rays."

Indiana Federation of Dentists, 101 F.T.C. at 184. Thus, the district court ruled that "[t]he order proposed by the Secretary of the F.T.C. would infringe on the State's right to regulate the practice of dentistry within the State as reserved to the State under its police powers by the Tenth Amendment to the Constitution of the United States." *Id.* at 148, 184. At the administrative hearing, the IFD argued that under the doctrine of collateral estoppel, the district court's ruling precluded any ruling by the ALJ on the issue of state action. The ALJ rejected this argument, determining that the district court's findings of fact and conclusions of law on the merits of this case were not necessary for the judgment of leave to intervene, and thus the doctrine of collateral estoppel was inapplicable. *Id.* at 143-52.

[11] *See supra* note 8.

> "the practical implementation of the [IFD] Work Rule was to refuse to cooperate with claims review programs which relied upon submission of x-rays. The effect of [the IFD member dentists'] conduct was to reduce competition among dentists to cooperate with dental reimbursement plans and, by doing so, to thwart the efforts of individual insurance companies to contain costs by offering coverage for only the least expensive adequate course of treatment."

Id. at 171-72. According to the Commission, the IFD member dentists' concerted refusal to comply with the insurers' directive to submit copies of a patient's dental x-rays along with the patient's claim form "*resulted in reducing or eliminating competition among dentists as to their policy of dealing with third-party payers.*" *Id.* at 173 (emphasis added). The Commission further found that:

> "In the absence of such concerted behavior, individual dentists would have been subject to the market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third-party insurers. By colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate."

Id.

In response to the IFD's argument that its conduct did not harm competition because "there was not an absolute 'shut off' of x-rays to insurance companies," the Commission found that the IFD's policy of allowing insurers' to attend the dentist's office and view all diagnostic aids, including the patient's x-rays, was

prohibitively expensive. The Commission surmised, without substantial evidentiary support in the record, that "even if the procedure were feasible at a higher cost, coercing parties into adopting such a procedure through collusion of competitors still distorts the competitive process." *Id.* The IFD further asserted that adherence to the IFD policy and accepted dental practice of examining all diagnostic aids before determining the proper course of dental treatment ensures patients of quality dental care and, in effect, promotes competition. According to the IFD:

> "Competition is naturally promoted among dentists who treat only after total diagnosis, in that their total treatment plan will be more successful from both a preventative viewpoint and long term maintenance of oral health. Error is less likely, thus reducing needed corrective work. Proper diagnosis will promote proper services, and satisfied patients will patronize those dentists."

Id. at 176. The Commission found, however, that this procompetitive justification was not supported by the evidence adduced at the administrative hearing. The Commission further found that "Indiana law does not affirmatively express any policy in favor of collusion among dentists in order to prevent or influence the use of x-rays by insurance companies" and thus the doctrine of state action did not exempt the concerted conduct of IFD member dentists from the Federal antitrust laws.[12] Accordingly, the Commission ruled

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[12] The Commission ruled that its consideration of the IFD's state action defense was not barred by the doctrine of collateral estoppel. According to the Commission, when the United States District Court for the Southern District of

that the "IFD's conduct constituted an unfair method of competition in violation of Section 5 of the FTC Act." *Id.* at 179. On appeal, the IFD contends that under a rule of reason analysis, the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market. In the alternative, the IFD contends that the state action doctrine exempts the IFD member dentists' conduct from the Federal antitrust laws.

II

The issue squarely before this court is whether the collective refusal of the IFD member dentists to comply with the group dental health care insurers' directive to submit copies of a patient's dental x-rays along with the patient's insurance claim form violates the Federal Trade Commission Act § 5. In our review of the Commission's order we are guided by the Congressional language of 15 U.S.C. § 45(c) (1982), that "[t]he findings of the Commission as to the facts, if supported by evidence, shall be conclusive." According to the settled law in this circuit, the Commission "may draw reasonable inferences from the record." *Spiegel, Inc. v. F.T.C.*, 540 F.2d 287, 293 (7th Cir. 1976) (citing *Consolo v. Federal Maritime Commission*, 383 U.S. 607, 620 (1966)). The Commission's findings of fact "are to be accorded great deference and are to be upheld if supported by sub-

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Indiana granted the State of Indiana leave to intervene in this lawsuit, the court's findings of fact and conclusions of law concerning the State of Indiana's regulation of the dental profession, "were not essential to the judgment ordered" and thus the doctrine of collateral estoppel did not apply.

stantial evidence." [13] *Kaiser Aluminum & Chemical Corp. v. F.T.C.*, 652 F.2d 1324, 1329 (7th Cir. 1981). *See also American Home Products Corp. v. F.T.C.*, 695 F.2d 681, 686 (3rd Cir. 1982); *RSR Corp. v. F.T.C.*, 602 F.2d 1317, 1320 (9th Cir. 1979), *cert. denied*, 445 U.S. 927 (1980). Thus, our review is limited to a determination of whether "the Commission applied incorrect legal standards which prejudiced its findings against petitioners . . . [and] whether the administrative decision is supported by substantial evidence in the hearing record before the examiner." *L.G. Balfour Company v. F.T.C.*, 442 F.2d 1, 7 (7th Cir. 1971).

In the instant case, the evidence reveals that the members of the IFD collectively agreed upon and drafted a dental policy statement, entitled IFD "work rule," setting forth the IFD position that "[p]roper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids, with a history and with all clinical findings." *Indiana Federation of Dentists*, 101 F.T.C. at 119, 129. This policy of quality and proper dental care comports with the Indiana dentists' code of professional conduct, as drafted by the Indiana Board of Dental Examiners, that the competent practice of dentistry requires "minimum standards of performance in diagnosis or treatment as measured against generally prevailing peer performance." 828 Ind. Adm. Code 1-1-15(b) (1984). The IFD policy also complies with the American Den-

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[13] The Supreme Court defines substantial evidence as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Consolo v. Federal Maritime Commission*, 383 U.S. at 619-20 (quoting *Edison Co. v. Labor Board*, 305 U.S. 197, 229 (1938)). *See also Steadman v. SEC*, 450 U.S. 91, 99-100 (1981).

tal Association's position that "[t]he dentist's primary obligation of service to the public shall include the delivery of quality care, competently and timely, within the bounds of the clinical circumstances presented by the patient. Quality of care shall be a primary consideration of the dental practitioner." ADA Principles of Ethics and Code of Professional Conduct at 2 (1983). Moreover, the IFD policy of quality and proper dental care provides that the dentist "has a moral and legal responsibility to not allow a determination of his patient's condition to be made for any purpose, without the benefit of a complete examination which takes into account" all diagnostic aids, with a complete patient history and all clinical findings. *Indiana Federation of Dentists*, 101 F.T.C. at 119, 129, 176. Implicit within this IFD policy of quality and proper dental care is a determination that the review of x-rays *alone* is ineffective and insufficient when formulating a proper course of dental treatment.

According to the ALJ's findings of fact, as adopted by the Commission, an x-ray establishes *only:*

> "tooth decay, an abcess, bone loss around the teeth or pathology in the bone itself.
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> • • • • •
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> *[E]ven a trained dentist can not determine the choice of restorative material just by looking at an x-ray, because that choice varies with how well the patient takes care of his teeth, which, in turn, affects how long the restorative material will last. . . . [Moreover] x-rays will not show the patient's mental condition, which is said to have considerable bearing on the treatment.*"

Id. at 129-30 (emphasis added). For these reasons, the ALJ found that "*the experts—on all sides—seemed to agree that an x-ray or other diagnostic aid alone is not enough for an accurate diagnosis.*" *Id.* at 131 (emphasis added). Similarly, the American Dental Association provides that a proper "diagnosis and treatment plan cannot be made from radiographs alone. Benefits shall not be determined solely on the basis of radiographic evidence. . . . *Proper dental treatment is predicated on a diagnosis from many types of examination and not radiographs alone.*" ADA Policies on Dental Care Programs 1974:653 at 34-35 (1984) (emphasis added). Thus, the IFD policy of quality dental care comports not only with the Indiana dental code and the American Dental Association code of professional conduct, but also with the American Dental Association's policy statement that a proper dental diagnosis involves many types of examinations and the ALJ's finding that an x-ray alone is not enough for an accurate dental diagnosis.

Indeed, just as a competent and qualified physician performs numerous tests for a recurring headache, to rule out a possible brain tumor, blood clot, migraine condition, dysfunction of the eyes, ears, or mouth, ruptured blood vessel, or drug reaction; a competent and qualified dentist, when prescribing a proper course of dental treatment, must examine and review the entire oral cavity, including the teeth, gum and mouth tissue, tongue, maxillary and mandibular bone structure, and loss of bone structure, along with a case history, x-rays, and all clinical findings. A thorough examination of this nature assures the patient of quality dental care and protects the dentist from future claims of negligence and possible dental malpractice. The evidence in this case

establishes that the IFD member dentists collectively adhered to their policy of quality and proper dental care, refusing to comply with the group dental health care insurers' directive to submit copies of a patient's x-rays without the benefit of examining and reviewing all diagnostic aids, a case history, and all clinical findings. Instead, the dentists uniformly responded to the insurers' x-ray directive with a form letter, prepared by the IFD, that provided in pertinent part:

> "It is the policy of this office to provide all diagnostic aids to third parties on an in-office basis and with the consent of the patient. . . . If you will have your consultant contact my office to set up an appointment, I will furnish records and ask the patient to be present for an examination."

Indiana Federation of Dentists, 101 F.T.C. at 122. In light of the evidence presented at the administrative hearing, it is clear that the collective refusal of the IFD member dentists to comply with the insurers' x-ray directive resulted from the dentists' adherence to a legal, moral, and ethical policy of quality dental care that requires a complete examination of all diagnostic aids before formulating a proper course of dental treatment. Accordingly, the focus of our review is whether the conduct of the IFD member dentists in adopting and collectively adhering to a policy that complies with the established, accepted, and approved standards of quality dental care constitutes a group boycott in violation of the Federal Trade Commission Act § 5.

A. GROUP BOYCOTT

In *Phil Tolkan Datsun v. Greater Milwaukee, etc.*, 672 F.2d 1280 (7th Cir. 1982), this court set forth the general rule that:

> "'*The classic "group boycott" is a concerted attempt by a group of competitors at one level to protect themselves from competition from non-group members who seek to compete at that level.* Typically, the boycotting group combines to deprive would-be competitors of a trade relationship which they need in order to enter (or survive in) the level wherein the group operates.'"

672 F.2d at 1284 (emphasis added) (quoting *Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1178 (D.C. Cir. 1978)). *See also Kreuzer v. Am. Academy of Periodonotology*, 735 F.2d 1479, 1493 (D.C. Cir. 1984); L. Sullivan, *Handbook on the Law of Antitrust* 230, 232 (1977). Contrary to the classic group boycott, the instant case does not involve a group of competitors banning together to protect themselves from non-group competitors. The record reveals that the IFD member dentists simply provide patients with quality dental care and pursuant to the terms of a collective bargaining agreement, the group dental health care insurers pay for the dentists' services. The record contains no evidence that the dentists compete with the insurers to attract patients, provide dental services, or prescribe dental treatment. Indeed, the ALJ found that "neither IFD nor any dentist member stands in the relation of competitor to any insurer . . . ." *Indiana Federation of Dentists*, 101 F.T.C. at 124-25. In light of the non-competitive market structure, we agree with the Commission that

the "conduct by the Indiana dentists involved a group decision to withhold [the submission of] x-rays from [insurance companies] *which were neither customers nor competitors*" and thus, the IFD's conduct was "not aimed principally at excluding competitors." *Id.* at 168 (emphasis added). The refusal to comply with the insurers' x-ray directive is not an attempt by the IFD member dentists to protect themselves from competitors; it is an adherence to a legal, moral, and ethical policy of quality and proper dental care. Thus, due to the fact that the group dental health care insurers are not competitors of the IFD member dentists, we hold that the dentists' refusal to comply with the insurers' x-ray directive does not constitute a classic group boycott.

Despite an absence of competition between the IFD member dentists and the group dental health care insurers within the State of Indiana, the Supreme Court has concluded that "the term 'boycott' is not limited to concerted activity against . . . competitors of members of the boycotting group." *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 552 (1978) ("*St. Paul Fire & Marine*"). *In St. Paul Fire & Marine*, four medical malpractice insurers in the State of Rhode Island allegedly entered into an agreement whereby three insurers refused to deal with physicians and hospitals within the state, thereby compelling the physicians and hospitals to accept curtailed medical malpractice insurance from the fourth insurer, in alleged violation of the Sherman Act § 1. The insurers argued that their activities were immune from Sherman Act scrutiny under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, which excepts the practice of insurance from the Federal antitrust laws. The physicians and hospitals argued that the insurers' activity constituted a boycott and pursuant to the express language of the McCarran-Ferguson Act § 3, 15 U.S.C. § 1013 (b), the Sherman Act remains applicable "to any agreement to boycott, coerce, or intimidate . . . ." According to the Supreme Court, "[*t*]*he generic concept of boycott refers to a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target.*" 438 U.S. at 541 (emphasis added). Based upon this broad definition of the term "boycott," the Court held that "[w]hatever other characterizations are possible, [the insurers'] conduct fairly may be viewed as 'an organized boycott' . . . ." *Id.* at 544 (quoting *Fashion Guild v. F.T.C.*, 312 U.S. 457, 465 (1941)).

This court has recognized that "'[t]he term "group boycott" . . . is in reality a very broad label for divergent types of concerted activity.'" *Phil Tolkan Datsun v. Greater Milwaukee, etc.*, 672 F.2d at 1285 (quoting *Mackey v. National Football League*, 543 F.2d 606, 619 (8th Cir. 1976), *cert. dismissed*, 434 U.S. 801 (1977); *U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d at 788. The broad label of "group boycott" generally applies to conduct involving a concerted refusal to deal, commonly defined as "an agreement by two or more persons not to do business with other individuals, or to do business with them only on specified terms." II E. Kintner, *Federal Antitrust Law* § 10.27 at 155 (1980). The instant case concerns an agreement among the IFD member dentists to adhere to established, accepted, and approved standards of quality dental care by requiring that the group dental health care insurers examine and review all diagnostic and

clinical aids before formulating a proper course of dental treatment. In furtherance of a legal, moral, and ethical policy that x-rays alone are ineffective and insufficient in formulating a proper course of dental treatment, the dentists refuse to submit copies of a patient's dental x-rays without the benefit of a complete diagnostic and clinical examination. Instead, the dentists expressly invite the insurers to visit their respective dental offices to review the patient's complete file, including reports compiled by dental specialists, the patient's case history, x-rays, all clinical findings, and examinations of the oral cavity, gum and mouth tissue, teeth, and bone structure.

The ALJ found that "most dentists have typically expressed their willingness to let insurers' 'qualified' experts come to their (the dentists') offices to look at x-rays and other diagnostic aids." *Indiana Federation of Dentists*, 101 F.T.C. at 125 n.337. The ALJ further found that "smaller insurers had generally gone along with the Indiana dentists' demands" to not require the submission of dental x-rays alone, but to review and examine all diagnostic and clinical aids in determining a proper course of dental treatment. Moreover, the evidence reveals that in 1972, dentists in the Allen County-Fort Wayne, Indiana area continually refused to comply with a request by the Aetna Insurance Co. to submit copies of a patient's x-rays along with the patient's dental claim form. Aetna responded by hiring a licensed dentist and "arranged for him to go to the office of each dentist concerned and work with the relevant x-rays and any other diagnostic aids in the dentist's files." *Id.* at 98. In January 1974, Aetna settled upon a plan whereby a licensed dentist would travel from

Aetna's Indianapolis office to Anderson, Indiana once a week to review x-rays and conduct in-mouth examinations at an estimated cost of $10 per patient.

In light of the fact that insurers have accepted the dentists' invitation to visit the dental office to examine and review all diagnostic and clinical aids, it is clear that the IFD member dentists did not engage in a *complete* refusal to deal with the group dental health care insurers. The dentists continued to treat all patients, including those covered by group dental health care plans, and thus continued to deal with the insurers on a regular basis. According to the record, the IFD member dentists simply agreed to require that group dental health care insurers do business on the dentists' terms, in compliance with established, accepted, and approved standards of quality dental care. Thus, the group boycott label in the instant case refers to the dentists' concerted effort to ensure quality dental care by requiring insurers to examine and review all diagnostic and clinical aids before formulating a course of dental treatment for purposes of a benefit determination. The dentists' conduct was neither a classic "group boycott" intended to protect dentists from competitors nor a complete refusal to deal with insurers in their efforts to control spiraling dental costs. In effect, the IFD member dentists adopted and implemented a policy that comports with legal, ethical, and moral standards of quality dental care but conflicts with the practice of group dental health care insurers to formulate a course of dental treatment and to determine insurance benefits based solely upon an insurance claim form and copies of a patient's dental x-rays.

B. RULE OF REASON

In reviewing the anticompetitive nature of the IFD member dentists' conduct, we initially note the Commission's observation that the "allegation of unfair methods of competition [against the IFD] is based on Sherman Act principles." *Id.* at 180 n.24. Indeed, the respondent, FTC, admits in its brief that the Commission analyzed this case under the Sherman Act § 1, 15 U.S.C. § 1, and the Federal Trade Commission Act § 5, 15 U.S.C. § 45. *See also Id.* at 124, 153.[14] Accordingly, our review of the Commission's order is guided by the legal principles of Federal antitrust law established under both the Sherman Act and the Federal Trade Commission Act. Foremost among these legal principles is that "[t]he 'rule of reason' is the established standard of analysis for determining whether [a Federal] antitrust violation" has occurred. *Bunker Ramo Corp. v. United Business Forms, Inc.*, 713 F.2d 1272, 1283 (7th Cir. 1983). *See also Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 343 (1982); *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977). The rule of reason "requires the factfinder to decide whether under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition." *Arizona v. Maricopa County Medical Society*, 457 U.S. at 343. *See also Monsanto Co.*

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[14] According to the Supreme Court in *F.T.C. v. Cement Institute*, 333 U.S. 683, 691-92 (1948), "soon after its creation the Commission began to interpret the prohibitions of § 5 as including those restraints of trade which also were outlawed by the Sherman Act, and . . . this Court has consistently approved that interpretation of the Act." *See also* 11 von Kalinowski, *Antitrust Laws and Trade Regulation* § 121.01 at 121-22 (1983).

v. Spray-Rite Service Corp., 104 S. Ct. 1464, 1469 (1984). According to the Supreme Court "[o]nce experience with a particular kind of restraint enables the Court to predict with confidence that the rule of reason will condemn it, it has applied a conclusive presumption that the restraint is unreasonable." *Arizona v. Maricopa County Medical Society*, 457 U.S. at 344. *See also N.C.A.A. v. Bd. of Regents of Univ. of Okl.*, 104 S. Ct. 2948, 2960 (1984); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 104 S. Ct. 1551, 1560 n.25 (1984); *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. at 50 n.16. This principle of *per se* unreasonableness "avoids the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries . . . ." *Northern Pac. R. Co. v. United States*, 356 U.S. 1, 5 (1958); *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 8 n.11 (1979); *Arizona v. Maricopa County Medical Society*, 457 U.S. at 344.

The Supreme Court further provides that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. at 49-50. *See also Northern Pac. R. Co. v. United States*, 356 U.S. at 5 (certain agreements or practices, because of their pernicious effect on competition and lack of any redeeming virtue, are conclusively presumed to be *per se* unreasonable). Additionally, "the *per se* rule is not employed until after considerable experience with the type of challenged restraint." *Broadcast Music, Inc. v. CBS*, 441 U.S. at 19 n.33. *See also Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 265 n.11 (7th Cir. 1981), *cert. denied*, 455 U.S. 921 (1982); *Havoco of America, Ltd. v.*

Shell Oil Co., 626 F.2d 549, 555 (7th Cir. 1980). In accord with these legal principles, the law in this circuit is well-settled that a *per se* analysis "should not be applied, and has never been applied by the Supreme Court, to concerted refusals that are not designed to drive out competitors but to achieve some other goal." *U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d at 788 (quoting *Smith v. Pro Football, Inc.*, 593 F.2d at 1180). *See also Kreuzer v. Am. Academy of Periodonotology*, 735 F.2d at 1491; P. Kissam, *Antitrust Law and Professional Behavior*, 62 Texas L.R. 1, 35-36 (1983). Based upon the Commission's finding that the conduct of the IFD member dentists is "not wholly motivated by an anticompetitive purpose, . . . is not aimed principally at excluding competitors," *Indiana Federation of Dentists*, 101 F.T.C. at 168, and our previous analysis of the market structure between dentists and insurers within the State of Indiana, it is clear that the IFD member dentists are not attempting "to drive out competitors." Rather, the dentists are adhering to a legal, moral, and ethical policy of quality and proper dental care, requiring that the insurers examine and review all diagnostic aids before denying or approving a proper course of dental treatment. The record clearly reveals that the IFD member dentists' conduct is not manifestly anticompetitive, nor has it been the subject of prior Federal antitrust analysis, thus we agree with the Commission that the IFD member dentists' conduct in adhering to their policy of quality dental care must be analyzed under a rule of reason. *Cf. Kreuzer v. Am. Academy of Periodonotology*, 735 F.2d at 1492 (if the boycott amounts to a public service, sufficient questions of competitive effect are raised to allow release from

per se treatment); *Wilk v. American Medical Ass'n*, 719 F.2d 207, 221 (7th Cir. 1983), *cert. denied*, 104 S. Ct. 2398 (1984) (the anticompetitive effect of a boycott in the medical profession is too uncertain to be amenable to *per se* treatment).[15]

The Supreme Court precedent clearly provides that "the inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." *National Soc. of Professional Engineers v. United States*, 435 U.S. at 691. According to the Court, under a rule of reason analysis:

> "the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the

[15] In *National Soc. of Professional Engineers v. United States*, the Supreme Court reasoned that professional services, including the medical profession, "by their nature . . . may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason." 435 U.S. at 696. We note, however, that the Court has applied a *per se* analysis in cases involving the medical profession; refusing "to tolerate manifestly anticompetitive conduct simply because the health care industry is involved." *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 104 S. Ct. at 1565-66 n.42. In the instant case, the conduct of the IFD member dentists is not manifestly anticompetitive. Moreover, our rule of reason analysis stems from the fact that the conduct of the IFD member dentists is not designed to drive out competitors but to promote a legal, moral, and ethical policy of quality and proper dental care. *See U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d at 787.

> reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences."

Chicago Board of Trade v. United Sta , 246 U.S. 231, 238 (1918). The rule of reason analysis "does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions." *National Soc. of Professional Engineers v. United States*, 435 U.S. at 688. Thus, "[u]nder the rule of reason, a showing of anticompetitive effect in the relevant market is an essential predicate of antitrust liability." *Phil Tolkan Datsun v. Greater Milwaukee, etc.*, 672 F.2d at 1287. *See also Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 104 S. Ct. at 1567. In this circuit "[i]t is . . . well established that any rule of reason anlysis requires a showing of anticompetitive market effect. To hold otherwise would ignore the very purpose of the [Federal] antitrust laws which were enacted for the protection of competition, not competitors." *U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d at 790 (quoting *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d at 268). *See also Wilk v. American Medical Ass'n*, 719 F.2d at 227 (under rule of reason analysis plaintiff must show that effect of conduct is to restrict competition rather than promote it); *Dos Santos v. Columbus-Cuneo-Cabrini Med. Center*, 684 F.2d 1346, 1352 (7th Cir. 1982) (under rule of reason analysis plaintiff must show the challenged restraint

has an adverse impact on competition in a relevant market).[16] Moreover, by requiring a showing of an anticompetitive effect in a relevant market we assure the consumer that the challenged activity actually harms competition, and thus we uphold the intended purpose of the Federal antitrust laws as a "consumer welfare prescription." *N.C.A.A. v. Bd. of Regents of Univ. of Okl.*, 104 S. Ct. at 2964 (quoting *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979)). *See also Products Liability Ins. v. Crum & Forster Ins.*, 682 F.2d 660, 663-64 (7th Cir. 1982); R. Bork, *The Antitrust Paradox* 66 (1978); 21 Cong. Rec. 2455, 2456-63 (March 21, 1890) (statement of Sen. Sherman).

C. ANTICOMPETITIVE EFFECT

In light of the pertinent case law, we review the Commission's findings of a relevant market and the anticompetitive effect that the IFD member dentists' conduct had therein. We initially note that the Commission's analysis of the relevant market consisted of a single paragraph placed within a footnote of the "Final Order":

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[16] According to the Commission, "[t]o assess the legality of the IFD restrictions under a rule of reason analysis, we must examine their nature, purpose and effect on competition, including an assessment of any possible procompetitive impact." *Indiana Federation of Dentists*, 101 F.T.C. at 168-69. The Commission's statement is not a complete and accurate statement of the rule of reason analysis. An *examination* of the effect on competition is not sufficient, there must be an actual *showing* that the alleged proscribed conduct has an anticompetitive effect in a relevant market. *Phil Tolkan Datsun v. Greater Milwaukee, etc.*, 672 F.2d at 1287; *U.S. Trotting Ass'n v. Chicago Downs Ass'n, Inc.*, 665 F.2d at 790; *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d at 268.

> "As in any rule of reason case, attention must be paid to market definition in order to assess competitive effects. No elaborate analysis is required here, since the record shows that under IDA's leadership, the conspiracy spanned many, if not most, localities in Indiana. *Under the ledership of IFD, it continued to be strong in the local areas covered by that organization's three chapters.*"

Indiana Federation of Dentists, 101 F.T.C. at 173 n.12 (emphasis added). Within this ambiguous relevant market (apparently including the IFD's chapters in Anderson, Ft. Wayne, and Lafayette, Indiana) the Commission found that the "IFD's concerted refusal to furnish x-rays to third-party payers substantially harmed competition among dentists by eliminating incentives for individual dentists to cooperate with cost-containment programs of third-party payers." *Id.* at 179. According to the Commission, this "concerted activity by competitors resulted in reducing or eliminating competition among dentists as to their policy of dealing with third-party payers." *Id.* at 173. The Commission further found that "[i]n the absence of such concerted behavior, individual dentists would have been subject to market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third-party insurers." *Id.* Thus, under a rule of reason analysis, the Commission found that within the area of the IFD's three separate chapters, the conduct of the 84 current and 8 former IFD member dentists had an anticompetitive effect *among dentists as to their policy of dealing with third party payers.*

It is important to note that the focus of the FTC's complaint and the basis of the Commission's finding was that the IFD member dentists' conduct harmed competition *among dentists in their policy of dealing with group dental health care insurers.* Neither the ALJ nor the Commission found that the dentists' conduct harmed competition among insurers, in their efforts to provide group dental health care coverage, nor among dentists, in their efforts to attract and treat patients covered by group dental health plans. Indeed, the Commission found that the "complaint did not clearly allege harm to competition in the dental insurance market, and conclusions about competitive harm to this market are unnecessary to our decision." *Id.* 101 F.T.C. at 174. Accordingly, the limited scope of our review is whether substantial evidence supports the Commission's finding that the dentists' adherence to a legal, moral, and ethical policy of quality and proper dental care and their refusal to comply with the insurers' x-ray directive, had an anticompetitive effect *among dentists in their policy of dealing with group dental health care insurers.*

The ALJ's "Initial Decision" and the Commission's "Final Order" are replete with references to the *clearly* and/or *plainly anticompetitve* conduct of the IFD member dentists in their policy of dealing with group dental health insurers. Implicit in this unsupported conclusory statement is a factual assumption that dentists in Anderson, Fort Wayne, and Lafayette, Indiana actually competed against one another in dealing with such insurers, and in complying with the insurers' directive to submit copies of a patient's dental x-rays along with the patient's claim form. The record is void of any finding that dentists

within these three areas did, in fact, engage in any form of competition in their policy of dealing with insurers or in complying with the insurers' x-ray directive. The record contains no substantial evidence nor thorough analysis of the total number of dental patients within the relevant market; the percentage of dental patients covered by group dental health care plans within the relevant market; the availability and proximity of dentists from surrounding areas of Indiana; the fees charged those patients covered by group dental health care plans, as compared to the fees charged patients without such coverage, within the relevant market; the policy of non-IFD member dentists in dealing with group dental health care insurers within the relevant market; or the general policy of dental insurers throughout the State of Indiana in examining a proposed or completed course of dental treatment for purposes of benefit determination. Indeed, the ALJ found that "*the record here is substantially deficient in evidence* as to just what supplementation of x-rays for diagnoses is the usual practice of the dental health care insurers serving Indiana." *Id.* at 132 (emphasis added). Upon examination of the record, the parties' briefs, the ALJ's "Initial Decision," and the Commission's "Final Order" we discern no analysis of the factors which are necessary and essential to a finding that dentists in Anderson, Fort Wayne, and Lafayette, Indiana do, in fact, compete with one another in their policy of dealing with group dental health care insurers. The Commission apparently assumed, without substantial evidentiary support in the record, that because the IFD member dentists acted in concert rather than individually, competition had to exist among and between dentists in their

policy of dealing with the insurers. An equally tenable argument, however, is that the IFD member dentists acted in concert because of their conviction to the legal, moral, and ethical policy of quality and proper dental care that requires a review of all diagnostic and clinical aids in formulating a proper course of dental treatment. *See, e.g., Kreuzer v. Am. Academy of Periodonotology*, 735 F.2d at 1494. Though the Commission's assumption of competition may be valid in the abstract, it is not supported by substantial evidence in the record.

Even if "reasonable inferences" could be drawn from the record to show that dentists in the relevant market did, in fact, compete in their policy of dealing with group dental health care insurers, the record is void of any substantial evidence to support the Commission's finding that the conduct of the IFD member dentists harmed this competition or had an anticompetitive effect. The Commission apparently reasoned that because the IFD member dentists had substantial market power within the Madison County-Anderson, Indiana area and the Allen County-Ft. Wayne, Indiana area, the dentists' collective adherence to their policy of quality and proper dental care altered these areas of the relevant market, allowing the dentists to refuse to comply with the insurers' x-ray directive without having to fear the potential loss of group dental health care patients. In support of this position, the Commission relied upon a letter written by the secretary of the Anderson IFD chapter, claiming that in September 1976, 95 percent of all practicing dentists in Madison County had joined the IFD. The Commission further relied upon a newsletter released by members of the Lafayette IFD chapter alleging that by September

1977, "all but a few dentists" in the four county Lafayette chapter were members of the IFD. Based upon these two separate letters, the Commission concluded that the IFD had substantial market power in two areas of the relevant market and that:

> "[i]n the absence of . . . concerted behavior, individual dentists would have been subject to market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third-party insurers. By colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate."

Indiana Federation of Dentists, 101 F.T.C. at 173. Though the documentary evidence relied upon by the Commission to find market power may be sufficient to warrant an investigation into the practices of the IFD and its member dentists, the evidence falls far short of establishing that the dentists' conduct altered the relevant market to harm competition among dentists in their policy of dealing with group dental health care insurers.

According to the Commission, the harmful effect of the IFD member dentists' conduct in adhering to their legal, moral, and ethical policy of quality and proper dental care was to eliminate "incentives for individual dentists to cooperate with [the insurers'] cost-containment programs" and thus to "thwart the efforts of individual insurance companies to contain costs by offering coverage for only the least expensive adequate course of treatment." *Id.* at 171-72, 179. We note that neither the ALJ nor the Commission delineated the alleged incentives available to dentists

for complying with the insurers' x-ray directive. Contrary to a finding of such incentives, the record clearly reveals that even when dentists refused to submit copies of a patient's x-rays along with the patient's claim form, group dental health care insurers continued to examine and process the patients' dental claim. We further note that neither the ALJ nor the Commission found that the submission of a patient's dental x-rays actually lowered the insurers' dental costs, or that the refusal to submit copies of a patient's x-rays actually increased dental costs. Indeed, the Commission expressly declined to consider these issues, claiming that "it is not for . . . the Commission to judge the efficiency of the arrangements selected by insurance companies to control costs." *Id.* at 175. *See also* D. Clanton, *FTC and the Professions*, 52 Antitrust L.J. 209, 218 n.33 (1983). In light of this evidence, it is clear that the Commission applied a "limited rule of reason analysis . . . but did not require elaborate proof of anticompetitive effect." D. Clanton, *FTC and the Professions*, 52 Antitrust L.J. at 218. As a result, the Commission's finding that the IFD member dentists' conduct had an *anticompetitive effect* among dentists in their policy of dealing with group dental health insurers is not supported by substantial evidence in the record.

A review of the evidence presented at the administrative hearing reveals that the IFD member dentists did not refuse to allow insurers access to a patient's dental x-rays. In furtherance of the established, accepted, and approved IFD policy of quality and proper dental care, the IFD member dentists allowed insurers to visit the dental office to review and examine the patient's x-rays along with all of the other diagnostic and clinical aids used in formulating a

proper course of dental treatment. The evidence reveals that the IFD member dentists continued to treat patients, including those covered by group dental health care plans, and continued to make dental diagnoses that were subject to review and approval by group dental health care insurers. Thus, the IFD member dentists, did, in fact, compete among themselves and with non-IFD dentists in their billing of patients covered by group dental health care plans and in their policy of dealing with the insurers.

According to the Commission, the IFD member dentists offer to insurers to visit the dental office to review and examine all diagnostic and clinical aids did not reduce the harm to competition.

> "While it is true that respondent was willing to allow *some* arrangement whereby x-rays could be examined by insurers—in particular, allowing insurers' consultants to make visits to the dentists' offices—the record is clear that this was prohibitively expensive . . . . Moreover, even if the procedure were feasible at a higher cost, coercing parties into adopting such a procedure through collusion of competitors still distorts the competitive process."

Indiana Federation of Dentists, 101 F.T.C. at 174-75, 125 n.337.[17] The Commission's finding is tem-

[17] The ALJ found that:

> "[T]here is unchallenged testimony in this record to the effect that it is not economically feasible and in any event it would be a terrible waste of time to have insurers' professional dental consultants constantly travelling from office to office to talk to dentists (when available) and look at their x-rays."

Indiana Federation of Dentists, 101 F.T.C. at 84.

pered by evidence in the record that "smaller insurers had generally gone along with the Indiana dentists' demands" and that group dental health care insurers did, in fact, visit dental offices to examine and review all diagnostic and clinical aids, including x-rays. Moreover, as long as the IFD member dentists continued to treat patients covered by group dental health care plans and invite their insurers to the dental office to review and examine all diagnostic and clinical aids, the IFD member dentists continued to compete among themselves and with non-IFD dentists in their policy of dealing with group dental health insurers. Any expenses resulting from the adherence to the IFD policy of quality and proper dental care affected the insurers in their review of dental claims, not the dentists in their competition for patients covered by group dental health care plans or in their competition to deal with the patients' insurers. The record clearly reveals that the IFD member dentists continued to compete in their policy of dealing with group dental health insurers; the dentists simply required that the insurers abide by established, accepted, and approved standards of quality and proper dental care, examining and reviewing all diagnostic aids before formulating a proper course of dental treatment.

The record is void of any substantial evidence to support the Commission's finding that the IFD member dentists' refusal to comply with the insurers' x-ray directive, had an anticompetitive effect among dentists as to their policy of dealing with group dental health care insurers. *Accord Boddicker v. Arizona State Dental Ass'n*, 680 F.2d 66, 68 (9th Cir.), *cert. denied*, 459 U.S. 837 (1982) (no arguments presented to demonstrate an adverse effect on competition between dentists). In effect, the Commis-

sion's finding of a Federal antitrust violation, based upon the insufficient evidence presented in this case, is a rubber-stamp approval of the group dental health care insurers' practice to formulate a course of dental treatment based solely upon dental x-rays and an insurance claim form, in violation of established, accepted and approved standards of quality dental care. There is no doubt that judicial sanction of such a practice, under the guise of the Federal Trade Commission Act, runs contrary to public policy and the very purpose of the Federal antitrust laws as a consumer welfare prescription. Indeed, by preventing dentists from joining together to promote standards of quality dental care that comport with the American Dental Association's code of professional conduct and the Indiana dental code, the Commission, with absolutely no expertise or training in the highly advanced field of dentistry, unwisely regulates the dental profession and all of its specialties, including endodontia, exodontia, oral surgery, orthodontia, pedodontia, periodontia, and prosthodontia, to the detriment of consumers. The group dental health care insurers cannot be permitted to forsake standards of quality and proper dental care in an attempt to lower their dental costs, particularly in the instant case where there has been no finding that the review of dental x-rays alone, actually reduces dental costs. According to the evidence presented at the administrative hearing, the IFD member dentists adhered to the legal, moral, and ethical policy of quality dental care, requiring that insurers examine and review all diagnostic and clinical aids before formulating a proper course of dental treatment. The record contains no substantial evidence to support a finding that adherence to the IFD policy had an anticompeti-

tive effect among dentists in their policy of dealing with group dental health care insurers. Thus, we hold that, under a rule of reason analysis, the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market, in violation of the Federal Trade Commission Act § 5.[18]

III

Based upon the foregoing analysis, we vacate the Commission's "cease and desist" order.

FAIRCHILD, *Senior Circuit Judge*, concurring in result.

This case deals with a significant problem in the operation of group dental insurance in Indiana. The insurance companies have contracted with employers to pay dental bills incurred by employees. The insurer's obligation is limited, however, by the standard of "least expensive adequate course of treatment." An opportunity to examine an x-ray in connection with a claim for services already rendered or preauthorization of a course of treatment aids the insurer in determining the amount of its obligation to pay, and serves the interests of both insurer and employer in keeping costs under control. Employee patients have an interest in prompt and full payment of their dental bills, as well as in the quality of care. Dentists have an interest in being paid for their

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[18] In light of this court's holding that under a rule of reason analysis the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market, we need not address the issue of state action.

service, as well as in freedom to exercise professional judgment in prescribing treatment.

There is little question that the Indiana Dental Association organized boycott of insurers' requests for x-rays had a significant economic impact on the functioning of group dental plans within Indiana. In 1974 IDA's membership included 85 to 88 percent of licensed dentists in Indiana. IDA's recommendation to its members to refuse to submit x-rays began as early as 1972 and achieved widespread compliance particularly in those counties where IFD would later form chapters. IDA's boycott forced group insurers to withdraw requests for the mailing of x-rays or face growing backlogs in patient claims. The experience of Aetna Insurance Company, provides an example. Aetna contracted to provide dental coverage to International Harvester employees in 23 states and several foreign countries. The Commission found that:

> Only in Indiana did Aetna experience any difficulty in obtaining x-rays for review of dental treatments. Within one year, there was a backlog of approximately 600 unpaid claims, because of Aetna's inability to verify the maximum allowable benefits. In a one-time effort to eliminate this backlog, the company's dental consultant visited the offices of all the dentists who had refused to submit x-rays and reviewed the claims with them, also urging them to submit x-rays in the future. There were two general reactions to his plea: 'one, dentists who said despite the fact that you seem fair, I will not send x-rays to you; and others who said I would like to, but I don't dare to.' In January, 1974, Aetna's consultants began doing in-mouth examinations of claimants

> in its Ft. Wayne office; they continued this practice until the end of November, 1978. In that period, the company conducted 4,700 exams at an estimated cost of ten dollars each. (Transcript reference omitted.)

By 1976 some leaders of the IDA inspired boycott became concerned that antitrust entanglements would begin to hinder IDA's already prolonged efforts to force group dental insurers to cease requesting submission of x-rays. These individuals decided to form a "dentist union" that they hoped would give dentists "more muscle" in negotiations with insurance carriers and be immune from antitrust liability. In August 1976 IFD was formed with members in at least six Indiana counties.

After formation, IFD actively encouraged its members to continue the IDA boycott. The record shows that companies operating dental insurance plans in counties with high IFD membership continued to face substantial resistance to requests for x-rays as late as January 1977.

Even viewing the IFD group independently of the IDA background, the size of IFD membership in a number of Indiana counties gave IFD the power to frustrate to a significant extent the insurers' need to review x-rays in those counties without going to exorbitant expense.

The substantial problem posed to the insurers by the concerted refusal to supply x-rays is clear. The difficult questions arise from the application of antitrust doctrine.

The underlying issue is the fairness of the practice of refusal, principally as it impacts insurers, but also as it affects employers and employee-patients. The complaint alleged that the concerted refusals were

unfair acts or practices. The FTC acknowledged that the record contained some evidence of consumer injury, but noted that neither the parties nor the ALJ had analyzed the issue of unfairness liability and declined to decide it. The FTC also concluded under the unfair methods of competition allegation a *per se* analysis is inappropriate, and that it must, under the rule of reason, examine the nature, purpose, and effect on competition of the concerted refusals.

Also acknowledging an argument by complaint counsel that the dentists' concerted action may have caused reduced competition among insurers, the FTC declined to make that finding. The FTC did find that the concerted refusals substantially limited competition among dentists. Thus the inquiry must be focused on competition among dentists, and whether concerted refusal to furnish x-rays to insurers curtails such competition.

I join in the result reached by the court, vacating the FTC order, because I conclude that the FTC analysis of the effect of the concerted refusal on competition among dentists is deficient.

Conceivably a dentist's willingness or unwillingness to supply x-rays to an insurer may be significant to an employee in choosing his dentist. Assuming that a prospective patient is aware of the practice of particular dentists in refusing or supplying x-rays, and the significance that refusal or cooperation may have to the patient's interest, he may choose one dentist over another. Presumably a patient would consider cooperation desirable because the bill would be paid more promptly. The IFD, however, might argue that refusal is an advantage to a patient because a dentist who decides to refuse puts a value on preserving his independent judgment of the patient's needs.

Pretty clearly, no evidence was developed on the validity of an assumption that a dentist's policy of refusal or cooperation has any significance in competition among dentists, and the FTC decision fails to analyze the proposition. It may well be that evidence could be produced to support a finding that this policy is really an element of competition among dentists and that a concerted policy of refusal does work a real injury to competition. But this analysis has not been made.

This deficiency is the reason I join in the court's result. There is much in the opinion in which I do not join, particularly in the repeated assertion that the concerted refusal resulted from a legal, moral and ethical policy of quality dental care and complied with established, accepted, and approved standards of such care. The relevance of these assertions is not clear. Insofar as they imply a finding that legal, moral and ethical considerations and approved standards were the sole cause of the concerted policy, they are in conflict with a clearly and adequately supported finding of the FTC of an economic motive. The FTC said,

> Moreover, it is clear that the concern of IDA's members over possible interference in the doctor-patient relationship was not limited to the effect such interference might have on patient welfare. It also extended to issues of professional pride and the economic well-being of Indiana dentists. Dr. McClure, who later became the first president of IFD, said in a speech to the association's Council on Dental Care Programs in 1974. 'We are fighting an *economic war* where the very survival of our profession is at stake. * * * The name of the game is money. The government

and labor are determined to reduce the cost of the dental health dollar at the expense of the dentist. There is no way a dental service can be rendered cheaper when the third party has to nave its share of the dollar.' * * *

With the formation of IFD, the economic motive became more explicit.

A true Copy:
Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

October 11, 1984

Before

HON. WILBUR F. PELL, JR., *Senior Circuit Judge*
HON. JOHN L. COFFEY, *Circuit Judge*
HON. THOMAS E. FAIRCHILD, *Senior Circuit Judge*

No. 83-1700

INDIANA FEDERATION OF DENTISTS,
an unincorporated association, PETITIONER

vs.

FEDERAL TRADE COMMISSION, RESPONDENT

Petition for Review of an Order of the
Federal Trade Commission

JUDGMENT—ORAL ARGUMENT

This cause came to be heard on the record from the Federal Trade Commission, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that the order of the Federal Trade Commission is hereby, VACATED, with costs, in accordance with the opinion of this Court filed this date.

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

December 21, 1984

Before

HON. JOHN L. COFFEY, *Circuit Judge*

HON. THOMAS E. FAIRCHILD, *Senior Circuit Judge*

HON. WILBUR F. PELL, JR., *Senior Circuit Judge*

No. 83-1700

INDIANA FEDERATION OF DENTISTS,
an unincorporated association, PETITIONER

vs.

FEDERAL TRADE COMMISSION, RESPONDENT

Petition for Review of an Order of the
Federal Trade Commission

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed in the above-

entitled cause by the Federal Trade Commission, Respondent, a vote of the active members of the Court was requested, and a majority * of the active members of the Court have voted to deny a rehearing *en banc*. A majority ** of the judges on the original panel have voted to deny the petition for rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for reeharing be, and the same is hereby, DENIED.

* Circuit Judges Richard D. Cudahy, Jesse E. Eschbach, and Richard A. Posner voted to grant the petition for rehearing *en banc*.

** Senior Circuit Judge Thomas E. Fairchild voted to grant the petition for rehearing.

UNITED STATES OF AMERICA
BEFORE THE
FEDERAL TRADE COMMISSION

Commissioners: James C. Miller III, Chairman
David A. Clanton
Michael Pertschuk
Patricia P. Bailey
George W. Douglas

Docket No. 9118

IN THE MATTER OF

INDIANA FEDERATION OF DENTISTS,
a unincorporated association

FINAL ORDER

This matter, having been heard by the Commission upon the appeal of respondent from the Initial Decision, and upon briefs and oral argument thereof and opposition thereto, and the Commission for the reasons stated in the accompanying Opinion having determined to deny the appeal of respondent Indiana Federation of Dentists,

IT IS ORDERED that the Initial Decision of the administrative law judge be adopted as Findings of Fact and Conclusions of Law except to the extent inconsistent with the accompanying Opinion. Other Findings of Fact and Conclusions of Law of the Commission are contained in the accompanying Opinion.

IT IS FURTHER ORDERED that the following Order to Cease and Desist is hereby entered.

I

IT IS ORDERED that the following definition shall apply in this Order: "third-party payer" means any entity that provides a program of reimbursement for dental health care services to employees or members of any other organization, and any person who provides evaluative services in connection with any such reimbursement program.

II

IT IS FURTHER ORDERED that respondent, its successors or assigns, and its officers and representatives shall cease and desist from engaging in any activity, course of conduct, practice, or policy that in whole or in part:

A. Requests, urges, recommends or suggests that dentists, or has the purpose or effect of requiring or organizing dentists to: (1) refuse to submit radiographs or other pre-treatment or post-treatment reports, analyses, and materials in response to a third-party payer's request for use in benefit determination; or (2) refuse to deal in any particular way with any one or more third-party payers;

B. Compels, threatens, or coerces any third-party payer to operate or deal in any way in connection with dental health care benefits program; or

C. Has the purpose of causing or inducing consumers to choose dentists who do not cooperate with third-party payers, or influencing to any degree consumers' choice of dentists based on the degree or manner of non-cooperation between such dentists and any third-party payer or payers.

III

IT IS FURTHER ORDERED that nothing contained herein shall be deemed: (1) to prohibit members of IFD, acting individually and not at the encouragement or inducement of IFD, from dealing with third-party payers in the way each sees fit; or (2) to prohibit respondent from adopting *bona fide* guidelines concerning the exposure of dental patients to radiation.

IV

IT IS FURTHER ORDERED that, within thirty (30) days after this Order becomes final, respondent shall mail to each of its members a copy of the Commission Order in this matter, as well as a letter, in the form shown as "Appendix A" to this Order, advising that respondent has abandoned all policies, guidelines, principles, work rules and statements that directly or indirectly request, urge, recommend or suggest that dentists, or have the purpose or effect of requiring or organizing dentists to: (1) refuse to submit radiographs or other pre-treatment or post-treatment reports, analyses, and materials in response to a third-party payer's request for use in benefit determination; or (2) refuse to deal in any particular way with any one or more third-party payers. The letter shall further advise that dentists are free to choose to deal with any such programs and payers in such manner as they decide individually. Respondent shall also mail a copy of the Order and the letter to every person who joins respondent within three (3) years of the date of service of this Order;

V

IT IS FURTHER ORDERED that, within sixty (60) days after service of this Order, and annually

on the anniversary date of the original report, for each of the five (5) years thereafter, respondent shall file with the Commission a report in writing, setting forth in detail the manner and form in which it has complied with this Order.

IT IS FURTHER ORDERED that respondent shall notify the Commission at least thirty (30) days prior to any proposed change in it, such as dissolution or other action resulting in the emergence of a successor organization, which may affect compliance obligations arising out of this Order.

By the Commission, Commissioner Douglas not participating.

/s/ Michael Baggage
Acting Secretary

[SEAL]

Issued: February 17, 1983

APPENDIX "A"

(Respondent's Letterhead)

Dear Doctor:

As you may be aware, the Federal Trade Commission has issued an order against the Indiana Federation of Dentists. This order requires, in essence, that the Indiana Federation of Dentists cease and desist from certain activities that are concerned with dental health care benefits programs and cooperation by dentists with the administrators of such programs. The order also requires that you be sent a copy of the order and this letter.

You are hereby notified that the Indiana Federation of Dentists has abandoned all policies, guidelines, and principles that directly or indirectly request, urge, recommend or suggest that dentists, or have the purpose or effect of requiring or organizing dentists to: (1) refuse to submit radiographs or other pre-treatment or post-treatment reports, analyses, and materials in response to a third-party payer's request for use in benefit determination; or (2) refuse to deal in any particular way with any one or more third-party payers. You are further notified that you are free to choose to deal with any such payers and programs in such manner as you decide individually.

A copy of the FTC's order is enclosed.

Sincerely,

_____

President

Enclosure

UNITED STATES OF AMERICA
BEFORE THE
FEDERAL TRADE COMMISSION

Commissioners: James C. Miller III, Chairman
David A. Clanton
Michael Pertschuk
Patricia P. Bailey
George W. Douglas

Docket No. 9118

IN THE MATTER OF

INDIANA FEDERATION OF DENTISTS

OPINION OF THE COMMISSION

By Pertschuk, Commissioner:

The practice of dentistry is not the selling of salt, aluminum, or tobacco. Dentists provide personal health services, not fungible goods. Moreover, the activities of professional associations contribute to the high level of health care in this country, just as trade associations help improve the quality of goods in many industries. But dentistry *is* a business, and the business practices of dentists are subject to the same antitrust law as are the business practices of manufacturers, jobbers, and retailers. Conspiracies and boycotts which substantially limit competition are methods of self-regulation that violate the very essence of our antitrust law. In this case, respondent joined and assumed leadership of a conspiracy of Indiana dentists to withhold patient x-rays from dental insurers, thereby frustrating their cost-containment

programs. We conclude that its methods were unacceptable and must be forsaken.

I. SUMMARY

The complaint in this case was issued on October 18, 1978, charging that the Indiana Federation of Dentists ("IFD") violated Section 5 of the Federal Trade Commission Act [1] by engaging in a concerted course of conduct with its members to eliminate or hinder competition among dentists with respect to their cooperation with the implementation of certain kinds of dental insurance programs. The complaint alleged that the conduct of IFD and its members was a continuation of the concerted action engaged in by the Indiana Dental Association ("IDA"), its members, and its component societies since at least 1961.[2]

Respondent IFD is an unincorporated association of Indiana dentists formed in August 1976. (CX 477 B-C; CX 22A)[3] Membership in IFD is open to any

[1] 15 U.S.C. § 45(a)(1) (1976).

[2] IDA was named as a co-conspirator but not as a respondent. At the time the Commission issued the complaint against IFD, it accepted provisionally a consent order from IDA. 43 Fed. Reg. 53767 (1978). That order was finally accepted in 1979. 93 F.T.C. 392.

[3] The following abbreviations will be used in this opinion:

ID	— Initial Decision, Finding Number
ID, p.	— Initial Decision, Page Number
Tr	— Transcript of Testimony, Page Number
CAB	— Complaint Counsel's Answering Brief, Page Number
RAB	— Respondent's Appeal Brief, Page Number
IAB	— Intervenor's Brief, Page Number
CX	— Complaint Counsel's Exhibit Number
RX	— Respondent's Exhibit Number
IX	— Intervenor's Exhibit Number

licensed dentist who endorses IFD's purposes and those of the American Federation of Physicians and Dentists, with which IFD is affiliated and to which each IFD member must belong. (CX 13C) IFD's membership is concentrated in and around the three localities of its chapters: Madison County, Daleville, and Middletown (Chapter #1) (CX 14A); Tippecanoe, Clinton, White, and Carroll Counties (Chapter # 2) (CX 15A); and Allen County (Chapter # 3) (CX 16A). As of February 1979, IFD had 84 dues paying members and 8 former members. (CX 12; ID 3) Its affairs are conducted by an eight-member executive committee, which includes a president, vice-president, secretary, and treasurer. (CX 13G-H-I) IDA is a "constituent society" of the American Dental Association; most Indiana dentists belong to IDA. (ID 14)

The gravamen of the complaint is that IDA, its component societies, and their members in agreement among themselves and with IFD and its members, through the distribution of guidelines, the conduct of meetings, workshops, pledge campaigns and other actions, engaged in a course of conduct to eliminate, prevent, or hinder competition among Indiana dentists with respect to their cooperation with third party payers administering dental health care insurance programs containing "predetermination" and "least expensive adequate course of treatment" provisions.[4] The complaint alleges that IFD has sought

[4] "Least expensive adequate course of treatment" provisions limit coverage to the least expensive treatment that is commonly accepted as providing good dental care. The more widely used name in recent years for this dental program feature is "alternative benefits" coverage. Programs that offer alternative benefits coverage usually allow dentists to submit treatment plans for approval before the treatment is

to hinder competition among dentists by encouraging its members to adopt a uniform course of conduct in dealing with such third-party payers and by urging payers, purchasers, and beneficiaries of dental health care plans to eliminate provisions of such plans that it finds unacceptable. Such conduct allegedly restrained competition among dentists, affected the cost of dental health care services in Indiana, deprived consumers of the benefits of cost-containment programs and second opinions, and limited the opportunity of consumers to select dentists who cooperate with dental health care benefits programs. At least, it is alleged, the conduct had the tendency or capacity to have such effects. The complaint alleges that these activities constitute unfair methods of competition and unfair acts or practices in violation of Section 5.

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provided, if it will cost more than a given minimum. Insurance companies encourage dentists to submit non-emergency expensive treatments for "predetermination," so that the treatment can be discussed and, ideally, disagreement between the dentist and the company as to what would constitute good care for the patient can be resolved before the treatment is provided. Whether or not agreement is reached, predetermination of benefits at least advises the patient and dentist—before treatment is provided—how much the insurance company will pay for treatment. While predetermination of benefits is encouraged, it is not *required* by either Connecticut General or Aetna (Tr 779, 1106) or, as far as we can discern from the record, by any other company offering a dental plan in Indiana.

Dental insurers commonly request copies of pretreatment (i.e., diagnostic) patient x-rays to use in evaluating dental treatments under alternative benefits coverage, particularly in evaluating more expensive treatments. If the dentist refuses to provide such x-rays, a claim for reimbursement may be denied entirely. (*See, e.g.*, ID 44)

Following the trial [5] the Administrative Law Judge ("ALJ") concluded that the Commission had jurisdiction over the respondent's practices since: (1) the respondent is a "corporation" within the meaning of Section 4 of the FTC Act (ID 4, 5); (2) it is not a labor organization within the meaning of the exemptions of Sections 6 and 20 of the Clayton Act (15 U.S.C. § 17 and 29 U.S.C. § 52) (ID 6); (3) neither it nor the "insurers" with whom its members have refused to cooperate are engaged in the business of insurance within the meaning of the McCarran-Ferguson Act (15 U.S.C. §§ 1012, 1013(b)) and, in any event, that Act does not exempt from the federal antitrust laws agreements to boycott (ID 7); and (4) respondent's conduct was a "substantial" restraint on interstate commerce. (ID 9-11) With respect to the merits, the ALJ found that respondent IFD was formed for the purpose of adopting or continuing IDA's conspiracy to keep Indiana dentists from submitting x-rays to dental insurers (ID 104) and that widespread compliance by IFD members with the IDA-IFD boycott policy was achieved. (ID 114) Additionally, the ALJ found that IFD and its co-conspirators threatened to prevent and to some extent prevented dental insurers from obtaining access to the services of dentists as dental consultants [6] except on respondent's terms (ID, p. 5), *i.e.*, dental

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[5] The trial began on October 2, 1979, and continued through November 1. The record, which includes approximately 440 exhibits and 2,785 pages of transcript from the hearings, was closed on November 16, 1979.

[6] "Dental consultants" refers to those dentists hired by dental insurers for the specific purpose of reviewing dental claims where there is a question as to the least expensive adequate course of treatment.

insurers encountered difficulty in hiring licensed Indiana dentists to review dental claims and those hired encountered heavy resistance. (*See, e.g.*, ID 45) The ALJ rejected respondent's state action defense (ID 149-185) and held that IFD's conduct constituted an unfair method of competition and an unfair practice in or affecting commerce in violation of Section 5 of the FTC Act. (ID 120-148; ID, p. 127)

The ALJ issued an order that, *inter alia*, provides for the dissolution of respondent within six months from entry of a final order and prohibits all dentists who have been members of IFD from agreeing to refuse collectively to submit consenting patients' x-rays to dental insurers.

Respondent argues on appeal that its alleged conduct did not have a substantial effect on interstate commerce and is also exempt from Commission scrutiny by virtue of the state action doctrine and collateral estoppel. Respondent claims further that its actions do not support a finding of liability under either a *per se* or rule of reason analysis, that no conspiracy was established, and that the proceeding is not in the public interest. Finally, with respect to the ALJ's order for dissolution, IFD maintains that the order is overly broad and not reasonably related to the alleged offense.

II. COMMERCE

Respondent's sole challenge to the Commission's jurisdiction is its argument that: (1) there is insufficient evidence to establish the required nexus between IFD's conduct to prevent the submission of x-rays to dental care insurers and the interstate commerce of the insurers, and (2) the record does not show that the alleged conduct of IFD had an effect

on the interstate commerce of the insurers. (RAB 56-57) Contrary to respondent's assertions, the ALJ concluded, as do we, that there is ample evidence to support the Commission's assertion of jurisdiction in this case.[7]

There is no serious question that the businesses of dental health care insurers, such as Aetna Life and Casualty Insurance Company and Connecticut General Life Insurance, that have been the target of IFD and IDA's activities are in interstate commerce. *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944). Even the insurance contracts themselves that gave rise to IFD and IDA's challenged conduct were interstate in character, as they were not mere personal contracts but agreements between national employers (*e.g.*, International Harvester and General Motors) and national insurance companies. Moreover, it is clear that the volume of business conducted by the companies in Indiana was substantial. (See ID 11 and ID, p. 24.) Thus, the only real issue is whether respondent's conduct has had the necessary connection with and effect on such interstate commerce.

Assuming *arguendo* that the provision of dental care services is wholly intrastate in character, it is nevertheless an integral element in the implementation of dental health care insurance plans. Moreover, unlike the restraint on title search services in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), that only indirectly affected the interstate financing of mortgages, any restraint on the cooperation of dental care providers with dental health care in-

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[7] Since only the interstate commerce challenge to jurisdiction was raised in respondent's post-trial brief, we regard its other jurisdictional defenses to have been abandoned.

surers can *directly* affect the business of those insurers. Indeed, respondent's conduct was purposely directed toward those businesses.

The ALJ concluded, based upon his reading of *McLain* v. *Real Estate Board of New Orleans, Inc.*, 444 U.S. 232 (1980), that the Commission's jurisdiction was sufficiently established by the fact that respondent's boycott was *designed* to affect adversely interstate commerce.[8] While such a finding alone may

[8] The *McLain* decision dealt with an alleged conspiracy to fix commission rates for real estate brokers. The ALJ relied on the following language in that opinion:

> To establish the jurisdictional element of a Sherman Act violation it would be sufficient for petitioners to demonstrate a substantial effect on interstate commerce generated by respondents' brokerage activity. Petitioners need not make the more particularized showing of an effect on interstate commerce caused by the alleged conspiracy to fix commission rates, or by those other aspects of respondents' activity that are alleged to be uniawful. The validity of this approach is confirmed by an examination of the case law. If establishing jurisdiction required a showing that the unlawful conduct itself had an effect on interstate commerce, jurisdiction would be defeated by a demonstration that the alleged restraint failed to have its intended anticompetitive effect. This is not the rule of our cases.

444 U.S. at 242-43. He apparently read this passage to support the conclusion that if the legitimate dental practices of respondent's individual members affected interstate commerce, it was unnecessary to show that the IDA-IFD conspiracy itself affected interstate commerce.

The ALJ is not alone in concluding that the holding of *McLain* was that "it was not necessary for the alleged antitrust violations complained of to have affected interstate commerce as long as defendants' business activities, independent of the violation, affected interstate commerce." Western Waste Service Systems v. Universal Waste Control,

be adequate, the record in this case shows that respondent's activities did in fact "substantially and adversely" affect interstate commerce. *Hospital Bldg. Co.* v. *Trustees of Rex Hospital*, 425 U.S. 738, 743 (1976).[9]

Since, as we will discuss below, IFD continued a conspiracy initiated by IDA, we begin by examining the effect of IDA's activities. A May 1972 edition of IDA's Manual on Group Funded Dental Care Programs declares in its "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care" that group dental care plans "must not *require* the dentist to submit radiographs to a third party." (CX 47E) The Manual's model "To All My Patients" letter includes the following:

> Dental radiographs are a part of the dentist's legal health records. They are available for

616 F.2d 1094, 1097 (9th Cir.), *cert. denied*, 449 U.S. 869 (1980). *Also*, Bain v. Henderson, 621 F.2d 959, 961 (9th Cir. 1980); Classen v. Weller, 516 F. Supp. 1243, 1244 (N.D. Cal. 1981). *Contra*, Crane v. Intermountain Health Care, Inc., 637 F.2d 715 (10th Cir. 1981). However, it is unnecessary for us to decide here whether this is the correct reading of *McLlain*, or whether the rule set forth in that case is applicable here, since the more stringent jurisdictional standards of *Goldfarb* and Hospital Bldg. Co. v. Trustees of Rex Hospital, 425 U.S. 738, 743 (1976), discussed above, can be satisfied.

[9] This and other cases decided under Section 1 of the Sherman Act have analyzed that Act to cover practices that "substantially and adversely" affect interstate commerce. Since Section 5 of the FTC Act governs practices "in or affecting commerce," practices within the Sherman Act's jurisdiction are necessarily also subject to the FTC Act. However, practices that do not meet the test for Sherman Act jurisdiction may nevertheless be subject to the FTC Act.

valid review by a qualified representative(s) of your insurance company *in this office*. Radiographs will not be submitted to third parties for their use in determination of benefits (e.g., least expensive adequate procedure, or optional course of treatment) because a determination of an adequate treatment plan can only be made after a knowledge of the following:

A. Complete patient evaluation.

B. Radiographs.

C. Additional diagnostic procedures as required.

(CX 47G) (emphasis added)

In 1973 IDA sought written pledges of support for its Principles of Acceptability from its members throughout Indiana. (Its membership in 1974 included about 85 to 88 percent of the state's dentists. (CX 303E)) The organization found the project to be a "tremendous success," with 100 percent support in some local societies. (CX 138; ID 27-32) In 1975, a survey of the actual practices of 2,000 of IDA's members, with 1,342 responding, showed that of 811 members receiving requests for x-rays from insurers, only 133 were providing them. (ID 33-34)

With respect to two particular dental insurers, Aetna and Connecticut General ("CG"), the record shows that: (1) at IDA's urging, many of its members, particularly in areas where IDA's organization was strongest, refused to provide x-rays for review; (2) through its leadership IDA as an organization pressured the companies not to request x-rays; and (3) the companies were forced to modify their normal practices in processing insurance claims in response to this concerted action in Indiana. This resulted in some cases in claims not being paid to insured patients or in their being delayed, and it also increased the companies' cost in administering their programs. (ID 39-80)

At its first annual meeting on April 24, 1977, IFD adopted a "Work Rule" declaring that a dentist "has a moral and legal responsibility to not allow a determination of his patients [sic] condition to be made *for any purpose*, without the benefit of a *complete examination* * * *." (CX 537A) (emphasis added) The new organization designed and distributed to its members a form letter for denying requests from insurers for x-rays (CX 586-A-B; CX 556A-B, F; CX 563C-D), which was widely used. (ID 114) (*See* ID, p. 85 for an illustrative letter.) After seeking x-rays from one Madison County member in early 1977, the manager of the CG office in Indianapolis concluded, on the basis of the reaction he received from IFD's representatives, that CG would have to continue its policy of excepting Madison County dentists from its normal procedures in processing dental claims. (ID 116, 117; Tr. 870-878) The representative of another insurer, Metropolitan Life Insurance Company of New York, testified that his company continued to request x-rays from IFD members and, when refused, did not pay benefits to the insured patient. (Tr. 1614-15)

From this and other evidence reviewed in the Initial Decision, the Commission concludes that respondent's activities have had a substantial effect on interstate commerce in the provision of dental health care benefits programs. (*See, particularly,* ID 11 and Figure 1, ID p. 24.)

III. CONSPIRACY

Respondent does not contest the ALJ's finding that IDA conspired with its members to boycott dental insurers. However, respondent asserts the absence of sufficient evidence in the record to sustain the ALJ's finding that IFD members conspired among themselves and with IDA to withhold dental x-rays from dental care insurers. We conclude, however, that the preponderance of evidence in the record supports such a finding.

The record here is rich with evidence from which a "reasonable inference" can be drawn of the adoption and continuation of IDA's activities by respondent and its members. *Eastern States Retail Lumber Dealers' Ass'n* v. *United States*, 234 U.S. 600 (1914); *Interstate Circuit, Inc.* v. *United States*, 306 U.S. 208 (1939). *See also United States* v. *Cadillac Overall Supply Co.*, 568 F.2d 1078, 1087 (5th Cir. 1978), *cert. denied*, 437 U.S. 903 (1978); *United States* v. *Consolidated Packaging Corp.*, 575 F.2d 117, 126 (7th Cir. 1978). Contrary to respondent's characterization of IFD as "a breakaway group of dentists who were dissatisfied with IDA policy" (RAB 58), the record shows that a major impetus for the formation of IFD was a growing apprehension that IDA's activities could be challenged successfully under the antitrust laws, coupled with a misimpression that a "dentists' union" would be immune from such action. (ID 87-98) Some IFD leaders also felt that a union could be more effective than IDA in dealing with dental insurers, and that a union was a "more suitable vehicle" than IDA for such activities. (ID 102) However, their intent was not to set off in a new direction, but rather to continue the same activities through a new organizational form. In addition to

evidence of this fact found by the ALJ in statements of IDA and IFD leaders before and immediately after the formation of IFD, there is evidence in the record that well after IFD was created, its leaders continued to view its mandate as one of continuing the IDA conspiracy. (*E.g.*, CX 540A, Tr 1715-16) The record contains evidence not only of the declaration of common objectives by the leaders of both organizations, but also of cooperation between members and leaders of both organizations (*e.g.*, CX 486A-C, CX 490A-B, CX 492A, CX 543A) and leadership by the same persons in both organizations in the formulation of policies for dealing with third party insurers. (ID 15 and Fig. 2, ID 16 and 25) Hence, we conclude that the record supports a finding of conspiracy between IDA and IFD, notwithstanding IDA's gradual withdrawal during the period that IFD was being organized.

With regard to the issue of whether respondent conspired with its members to withhold x-rays, the record is replete with evidence of adherence to common objectives and of coordinated activities by respondent and its members. First of all, a major formal objective of IFD, as stated in its Constitution and by-laws, is "[t]o represent dentists in all socio-economic matters, negotiations and grievances with employers, third, and fourth parties or any group that is involved in financing or delivery of dental care." (CX 13A) Subsequent to IFD's formation, the IFD Work Rule was adopted at an annual meeting of the full membership. (CX 537A) By direction of the Executive Board (CX 541A), the Work Rule was printed on the back of a claim form created by IFD for its members. (CX 542A-B) This form was used by members refusing to submit x-rays to dental in-

surers. (CX 680-682; CX 713; CX 718) IFD members also used a common form letter to deny requests for x-rays. (CX 586A-B; ID 114 and ID p. 85) On at least two occasions, IFD's President responded on behalf of another IFD member in refusing to submit x-rays. (CX 652, 653; CX 654, 655) On another occasion, a request to an IFD member resulted in a call from IFD's Vice President; this call further resulted in a meeting between IFD representatives and a manager of CG, after which CG refrained from making further requests of Madison County IFD members for x-rays. (ID 117) IFD's President also represented its members in a meeting with another dental insurer and the union and Madison County employer whose dental plan was administered by that company. (ID 118) He stated that IFD members would not submit x-rays. (Tr 1625) IFD's policy to withhold x-rays was also expressed by its representatives in meetings with other employers and unions. (*E.g.*, Tr 1665-1667, CX 544A.) Hence, we conclude that there is ample evidence in the record to support a conspiracy among members of IFD and between IFD and its members.

IV. SECTION 5

Respondent is alleged to have engaged in unfair methods of competition by conspiring with certain Indiana dentists to refuse to provide x-rays to dental insurers for use in benefits determination. Central to the Commission's complaint is the following charge:

> "PARAGRAPH ELEVEN: Since September 1976, respondent and its members, in concert and agreement among themselves, have acted in furtherance of the agreement and concert of

> action alleged in PARAGRAPH NINE, and have otherwise engaged in acts, practices, and methods of competition to eliminate, prevent, or hinder competition among dentists with respect to cooperation with dental health care benefits programs containing predetermination and least expensive course of treatment provisions * * *."

As described in paragraph nine of the complaint, the specific acts and practices include: (1) promulgating guidelines and principles for dealing with third-party payers, along with forms and information to facilitate adherence to them; (2) encouraging members to refuse to serve as dental consultants for third-party payers and to refuse to provide x-rays to them for use in benefits determination; and (3) conducting meetings and pledge campaigns among their members to gain the agreement of individual members not to compete with other dentists in dealing with third-party payers.

The ALJ found that IFD had engaged in these practices. We agree that the record shows clearly that IFD pursued these practices, principally as a follow-up to the activities of the IDA before IFD was formed. The respondent, in fact, does not appear to dispute vigorously that it engaged in these practices but rests its case primarily on the proposition that the conduct was not unlawful under a rule of reason analysis and that it was justified for reasons related to the quality of dental care. In particular, IFD argues that "under the rule of reason the pro-competitive or beneficial effect of respondent's alleged conduct on health and safety, outweighs any anti-competitive or anti-consumer effects." (RAB 4)

The ALJ found that respondent's conduct amounted to a *per se* violation of Section 5 of the FTC Act on

the grounds that it constituted a group boycott which is unlawful *per se*. In addition, however, the ALJ found that IFD's conduct substantially harmed competition under a rule of reason analysis so as to violate Section 5 even under a more far-reaching examination of competitive effects.

In reviewing the ALJ's findings, we address first the proper standard of analysis of the reasonableness of the alleged acts and practices. The Supreme Court has stated that some practices which restrain competition should be held *per se* unlawful without the need for substantial inquiry into their competitive effects. Thus, some practices which have been consistently found to harm competition with little or no competitive justification are held *per se* unlawful in order to avoid "the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large whether a particular restraint has been unreasonable —an inquiry so often wholly fruitless when undertaken." *Arizona* v. *Maricopa County Medical Society*, 50 U.S.L.W. 4687, 4691 (U.S. June 18, 1982), quoting *Northern Pacific Railway Co.* v. *United States*, 356 U.S. 1, 5 (1958).

Accordingly, courts have determined that *per se* illegal practices include, for example, horizontal division of markets, *United States* v. *Topco Associates, Inc.*, 405 U.S. 596 (1972); price fixing agreements, *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); and group boycotts, *Fashion Originators' Guild of America, Inc.* v. *Federal Trade Commission*, 312 U.S. 457 (1941); *Klor's Inc.* v. *Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959).

Examination of the group boycott cases reveals some which involve agreements between businesses

which were designed to exclude or limit actual or potential competitors from the market. For example, in *Fashion Originators'*, 312 U.S. at 467-468, wholesale firms with a substantial market share sought to prevent potential competition from so-called "style pirates" by agreeing to implement an elaborate enforcement plan and an agreement not to sell to nonconforming firms. The Supreme Court held, notwithstanding the tortious nature of the conduct of the "pirates," that the wholesalers' boycott agreement and enforcement plan were *per se* illegal. 312 U.S. at 467-68. In *Klor's*, 359 U.S. at 211-212, the Supreme Court held *per se* illegal an agreement by several manufacturers not to sell to a single retailer upon the solicitation not to deal by the retailer's competitor.

Other group boycott cases involve practices implemented for the purpose of extracting more advantageous business terms or practices for economic gain. For example, in *Paramount Famous Lasky Corp.* v. *United States*, 282 U.S. 30 (1930), an agreement among competing film distributors to utilize only a standard form contract, which contained binding arbitration of disputes provisions, in transactions with film exhibitors and an agreement to refuse to deal with non-conforming exhibitors were held to comprise an illegal concerted refusal to deal. Although the Court had not yet clearly distinguished the *per se* and rule of reasons approach to analysis of restraints on competition, the film distributors' agreement was found unlawful without an elaborate inquiry about competitive effects. The contract arrangement in *Paramount Lasky* would have resulted in a highly probable anticompetitive effect because it eliminated competition as to key provisions in contracts with film exhibitors.

The Supreme Court made clear in *St. Paul Fire & Marine Insurance Co.* v *Barry*, 438 U.S. 531 (1978), that the concept of "boycott" includes a concerted refusal to deal with another party in an effort to obtain advantageous terms in the commercial relationship. *Id.* at 541. However, the Court did not decide whether a concerted refusal to deal, as examined in *Barry*, was subject to the *per se* test of illegality. *Id.* at 544.

Despite the fact that at least some types of group boycotts have been found unlawful *per se*, we disagree with the ALJ that a *per se* analysis is appropriate here. First, we note that the type of restrictions on competition encountered here have not been the subject of frequent prior antitrust analysis. The conduct by the Indiana dentists involved a group decision to withhold x-rays from parties which were neither customers nor competitors. IFD conspired to withhold a tool of medical diagnosis, the x-ray, rather than all significant aspects of the dentist-insurer transaction. Finally, this arrangement arose in the context of health providers' bargaining with third-party payers as to the mechanisms which could be used to review claims. Because there has not been extensive analysis by the Commission or the courts of this type of restraint, a *per se* analysis is less appropriate. *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *American Medical Ass'n* v. *FTC*, 94 F.T.C. 701, 1003 (1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 50 U.S.L.W. 4313 (U.S. March 23, 1982).

Second, we observe that the respondent's conduct is not wholly motivated by an anticompetitive purpose. While, as we discuss below, the practices do

have a significant effect in reducing competition, they arise in the context of proffered justifications for their use and thus, are not "naked restraints of trade with no purpose except stifling of competition," which would make a *per se* analysis more appropriate. *Broadcast Music*, 441 U.S. at 20; *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963).

Third, as discussed above, it is not clear that this type of group boycott should be subject to a *per se* analysis, even when viewed as one of a class of restraints with which courts have had long experience. While it limits competition among participants in the boycott, it is not aimed principally at excluding competitors. Thus, while we do not express a view as to whether any boycott which is not aimed at excluding competitors should be analyzed under a rule of reason, the lack of clear precedent for a *per se* analysis in this situation is another reason for engaging in an inquiry about competitive effects.[10]

Therefore, we turn to a consideration of the reasonableness of respondent's no-submission requirement. The test of legality is "whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918); *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 691 (1978). To assess the legality of the IFD restrictions under a

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[10] We note that the Supreme Court has recently stated that a rule of reason analysis is not appropriate merely because of the peculiar characteristics of the health care market or because professionals are parties to the challenged conduct. Arizona v. Maricopa County Medical Society, 50 U.S.L.W. at 4691.

rule of reason analysis, we must examine their nature, purpose and effect on competition, including an assessment of any possible procompetitive impact. *Chicago Board of Trade*, 246 U.S. at 238.

The full scope and effect of IFD's own practices can be fully understood only by examining also the activities of IDA and IFD's relationship to IDA.[11] As we discussed in Part II, IDA adopted a manual, which was distributed to all IDA members, specifying "Principles of Acceptability" for dental insurance plans, including the condition that these plans not require the submission of x-rays. The manual contained form letters to be given to patients stating that x-rays would be available to insurers only in the dentist's office and, by inference, directed member dentists not to violate this condition for an "acceptable" dentist-insurer relationship. In addition to distributing this manual, in 1973 IDA conducted a campaign to obtain signed pledge cards from its members by which member dentists promised to comply with the manual's principles. More than 85 percent of the membership promised to comply. (CX 74A) Subsequently, in 1975, IDA conducted a mail survey to determine compliance.

Although IDA's official policies always focused on the use of x-rays by dental insurers, the record evidences a discernable undercurrent of hostility toward third party payment plans as a whole, and particularly plans that contained alternative benefits limita-

[11] "Late-comers to antitrust conspiracies, who, while knowing of the prior existence of the conspiracy, join it in order to promote the unlawful object for which it was organized, are liable for everything done during the period of the conspiracy's existence." *In Re Nissan Motor Corp. Antitrust Litigation*, 430 F. Supp. 231, 232 (S.D. Fla. 1977).

tions. Announcing the organizational meeting for the pledge campaign, the co-chairmen, Drs. Rohn and McClure, began their letter: "As you know, there is significant rapid growth of group-funded dental care programs in Indiana. The IDA has *prepared to meet this challenge* through the development and implementation of the 'Indiana Plan.'" (emphasis added) The letter continued to warn that "we must make sure the 'Indiana Plan' continues to work and work well, or we stand the chance of being dictated to by some distant third party." (CX 125) The back of the IDA Approved National Dental Claim Uniform Report Form contained a note to dental patients that included the following:

* * * *

> In some plans, the dental insurance contract is written to provide for the least expensive, adequate procedure as determined by the insurance company. The carrier will request x-rays to make this determination. If your contract is written in these terms, please give special attention to the following:
>
> A. The Indiana Dental Association does not agree with such a contract.
>
> * * * *
>
> (CX 75D)

Similarly, the sample letter to insurers contained in the IDA manual included this explanation for the refusal to submit requested x-rays: "As you know, the Indiana Dental Association's Principles of Acceptability advise dentists not to submit radiographs to a third party because the use of these (x-rays) interfere [sic] with the dentist's professional judg-

ment by altering or suggesting alternative methods of treatment, and possible legal involvement if the radiographs were lost." (CX 47X)

Moreover, it is clear that the concern of IDA's members over possible interference in the doctor-patient relationship was not limited to the effect such interference might have on patient welfare. It also extended to issues of professional pride and the economic well-being of Indiana dentists. Dr. McClure, who later became the first president of IFD, said in a speech to the association's Council on Dental Care Programs in 1974: "We are fighting an *economic war* where the very survival of our profession is at stake. (emphasis added) * * * The name of the game is money. The government and labor are determined to reduce the cost of the dental health dollar at the expense of the dentist. There is no way a dental service can be rendered cheaper when the third party has to have its share of the dollar." (CX 372A) Reviewing some of the "problems" with existing insurance plans, he predicted: "The fight for x-rays will continue, although I have reasons to believe they may start off without them, they will eventually switch to this method of determining benefits. *This is the only way they can control their costs.*" (emphasis added) (CX 372E)

With the formation of IFD, the economic motive became more explicit. As IFD's first Secretary explained in a letter to an Evansville dentist during the formation of the federation: "If you will read the object of the association [ADA] in constitution and by-laws, you will realize that the association was not designed nor intended to represent us in socio-economic or political areas. * * * It is our opinion that a more suitable vehicle is needed to represent us

in these areas and that a union is the most advantageous choice to satisfy the needs previously mentioned." (CX 484A-B) IFD's Constitution and By-laws state thirteen objectives for the organization. The first four are the following:

> (a) To represent dentists in *all socio-economic matters*, negotiations and grievances with employers, third and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public,
>
> (b) To seek to insure *adequate compensation* and proper working conditions for dentists commensurate with their training and skill and the responsibility they bear for the life and health of their fellow human beings,
>
> (c) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of the highest quality of dental care,
>
> (d) To associate together all dentists for their mutual benefit and protection * * *.
>
> (emphasis added) (CX 14A)

These objectives were emphasized in communications among members. For example, the June 1, 1978, newsletter of IFD Chapter II stated: "Those of us in the I.F.D. believe that WE are the ONLY organization uniquely set up to protect the socio-economic areas of our members. The working conditions of our

members is [sic] important to us and must remain foremost in our actions." (CX 499A)

As we discussed more fully in Part III, there is no doubt that IFD was created to follow up on IDA activities and goals. It is equally clear that a major reason for creating IFD was to avoid the antitrust laws under the mistaken impression that IFD would be exempt as a "union." (CX 476B; CX 484A; CX 489B) IFD included in its Constitution a procedure for authorizing "strikes, job actions, or other forms of economic pressure" by local chapters to accomplish its objectives. (CX 13Q) Moreover, the Constitution provided for discipline of IFD members for failure to conform to the Constitution and By-laws and for "any action detrimental to the welfare of this organization." (CX 13T-U) While the Constitution did not provide a sanction specifically for failure to participate in a boycott, the Executive Committee considered on at least two occasions the question of "retaliatory gestures" against dissident members and clearly considered "severe measures" of reprisal a possibility, albeit as a last resort. (CX 512A and CX 522; Tr 2429-31)

In 1977 IFD adopted and disseminated the IFD Work Rule, which provided that a dentist has a responsibility to prevent a determination of a patient's condition without the benefit of a complete dental examination. The clear understanding of this rule was that insurance company use of x-rays (without an examination of the patient) in claims review was a form of "determination" of the patient's condition that the dentist was obliged to prevent. After formal adoption of IFD's Work Rule, dentists, using a form prepared by IFD, refused to provide x-rays to third-party payers. Thus, the practical implementation of

the Work Rule was to refuse to cooperate with claims review programs which relied upon submission of x-rays. The effect of respondent's conduct was to reduce competition among dentists to cooperate with dental reimbursement plans and, by doing so, to thwart the efforts of individual insurance companies to contain costs by offering coverage for only the least expensive adequate course of treatment.

There is no doubt that IDA's practices, later continued by IFD, had an effect on the way in which dentists cooperated with dental insurance plans. It is quite clear that dental insurance companies were unable to obtain x-rays with the regularity and frequency desired in order to carry out their claims review process. Aetna, for example, began a program for employees of International Harvester on July 1, 1971. The plan covered employees in primarily 23 states and several foreign countries. (ID 40; RX 99B) Only in Indiana did Aetna experience any difficulty in obtaining x-rays for review of dental treatments. (RX 99B-C; Tr 1243) Within one year, there was a backlog of approximately 600 unpaid claims, because of Aetna's inability to verify the maximum allowable benefits. (Tr 1267, 1274) In a one-time effort to eliminate this backlog, the company's dental consultant visited the offices of all the dentists who had refused to submit x-rays and review the claims with them, also urging them to submit x-rays in the future. (Tr 1268) There were two general reactions to his plea: "one, dentists who said despite the fact that you seem fair, I will not send x-rays to you; and others who said I would like to, but I don't dare to." (Tr 1275) In January, 1974, Aetna's consultants began doing in-mouth examinations of claimants in its Ft. Wayne office; they continued this practice

until the end of November, 1978. (Tr 1276-79) In that period, the company conducted 4,700 exams at an estimated cost of ten dollars each. (Tr. 1279)

CG also modified its practices in an effort to deal with IDA's demands. CG came to a "gentleman's agreement" with IDA whereby the claim form would continue to require x-rays but CG would not insist on the dentist's compliance. (ID 74) CG also allowed a dental consultant, approved by IDA, to operate out of the dentist's own office rather than CG's claim office as a result of IDA pressure. (ID 78) Both of these cases illustrate an insurance company, confronted by the economic power of united dentists, responding to that economic power rather than to a dental services market characterized by competition among dentists.

Moreover, it is clear that IFD's practices continued to have an effect similar to that initiated by IDA; they were, indeed, an effective continuation of the IDA conspiracy. IFD representatives met with CG to discuss CG's x-ray submission policies, a meeting which concluded in CG's decision not to make further x-ray requests from Madison County dentists. (ID 117) IFD's President, Dr. McClure, also met with a representative of Brockway Glass, an employer located in Madison County, which had arranged for employee dental coverage through Metropolitan Life Insurance Company. McClure stated that the federation of dentists he represented would not submit x-rays. (ID 118; Tr 1625) In short, the record contains numerous examples where the dentist-insurance company relationship that would have existed in the absence of this market power was altered.

There is no doubt that IDA and IFD were able to achieve substantial market power by colluding. In 1974, 85-88 percent of Indiana dentists belonged to IDA. (CX 303E) In particular areas, IFD was

able to achieve remarkably high degree of participation. In Madison County, 95 percent of all practicing dentists had joined IFD Chapter I by September 8, 1976, according to the chapter's secretary. (CX 484B) The Chapter II news letter reported in September, 1977, that "[a]ll but a few dentists in our four county area are now members of the Federation." (CX 549A) Even though the actual total membership of IFD was small, its market power in some localities was clear from its effect on the behavior of insurers and the functioning of the dentist-insurer relationship.[12]

Such concerted activity by competitors resulted in reducing or eliminating competition among dentists as to their policy of dealing with third-party payers. Patients who were covered by dental plans providing for cost-containment programs such as those here found it difficult to purchase care from dentists who would satisfy the terms of their coverage. In the absence of such concerted behavior, individual dentists would have been subject to market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third-party insurers. By colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate. Consequently,

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[12] As in any rule of reason case, attention must be paid to market definition in order to assess competitive effects. No elaborate analysis is required here, since the record shows that under IDA's leadership, the conspiracy spanned many, if not most, localities in Indiana. Under the leadership of IFD, it continued to be strong in the local areas covered by that organization's three chapters. The record shows no competition from out-of-state dentists, except in two localities near Louisville, Kentucky. (CX 151B; CX 186C; CX 76F)

the dentist-insurer relationship was determined by economic coercion, not by market competition. The final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs.

Complaint counsel have argued that the conspiracy had other effects on competition, including that insurers were less able to compete on the basis of cost-containment and that patients were deprived of information that might lead them to switch dentists. As for the effect on competition in the dental insurance market, we agree that a secondary effect of concerted behavior on the part of dentists was to prevent insurers from implementing cost-containment efforts. This may well have reduced competition among insurers. The record shows that dental insurance grew in significance in Indiana beginning in the mid 1970's as various insurers offered group coverage to employers. Inevitably, a principal concern of both employer and employee groups was the premium. Consequently, both employer and employee groups were concerned about cost-containment measures practiced by insurers. This concern is illustrated by General Motors' insistence that its claim form continue to require x-rays, despite CG's willingness to provide an explicit exemption for IDA members. (CX 327W) Similarly, Aetna representatives told IFD representatives that Aetna's market survival required cost-containment measures. (CX 284B)

Concerted behavior among competitors which prevents or hinders the marketing of goods or the implementation of services by competitors in another market may harm competition in that other market.[13]

[13] For example, in *Fashion Originators'*, concerted action by manufacturers to protect themselves from competition by "style pirates" also harmed competition at the retail level by narrowing the sources from which retailers could buy dresses. 312 U.S. at 465. In another case, a boycott by lumber retailers of wholesalers that were also competing at retail affected not only retail competition but also impeded wholesale trade by reducing the number of potential purchasers from the boycotted companies. Eastern States Retail Lumber Dealers' Ass'n v. United States, 234 U.S. 600, 614 (1914).

Here, respondent's efforts to achieve a uniform course of conduct among dentists in their dealings with dental insurers affected a significant aspect of the insurers' businesses, i.e., the operation of cost-containment efforts through the "alternative benefits" mechanism. The harm to these efforts may have reduced competition among insurers by preventing them from competing on the basis of reduced premiums. Respondent's activities may also have prevented new entrants from obtaining customers by offering innovative and effective cost-containment measures. However, despite complaint counsel's argument, the Commission's complaint did not clearly allege harm to competition in the dental insurance market, and conclusions about competitive harm to this market are unnecessary to our decision. Accordingly, we decline to make such a finding.

Respondent makes a variety of contentions that the collective refusal to provide x-rays did not harm competition, including the assertions that there was not an absolute "shut off" of x-rays to insurance companies (RAB 15-16) and that the benefits of predetermination are not well-established and might cost more than they are worth. (RAB 17) While it is true that respondent was willing to allow *some* arrangement whereby x-rays could be examined by insurers—in particular, allowing insurers' consultants

to make visits to the dentists' offices—the record is clear that this was prohibitively expensive. (ID p. 89, fn. 337) Moreover, even if the procedure were feasible at a higher cost, coercing parties into adopting such a procedure through collusion of competitors still distorts the competitive process. Commercial dealings are structured by leverage of combined market power rather than by competition.

Finally, we reject the IFD's position that to establish liability, the record must establish that predetermination, or more generally, use of x-rays by dental insurers to determine what services they will pay for under alternative benefits coverage, is effective in containing costs. (RAB 17) We do not require an analysis of the actual net impact on the operating costs of insurers or of the actual dollar losses to policyholders or employers in order to conclude that respondent's actions are anticompetitive. The task of identifying the precise impact of these types of restrictions and segregating the effects of other forces is likely to be infeasible. *See, AMA*, 94 F.T.C. at 730. To require such a showing would often impose an impossible burden on complaint counsel and preclude prohibiting plainly anticompetitive restraints until their precise impact could be measured. Moreover, it is not for IFD or the Commission to judge the efficiency of the arrangements selected by insurance companies to control costs. An antitrust violation cannot be justified on the grounds that it sought to remedy a poor business decision by the targets of a boycott. It is enough that the restraint is shown to have significantly distorted the competitive process by forcing insurers to comply with the demands of united competitors, thereby significantly altering the nature of their claims review process and

their attempts to implement cost-containment measures.

In summary, we find that IFD's practices substantially limited competition among dentists in their willingness to cooperate with dental insurance cost-containment programs.[14] We turn now to respondents' principal argument in defense—that the restraints on competition resulting from the challenged concerted behavior resulted in benefits adequate to offset any anticompetitive effect. IFD claims that the restraints had a procompetitive effect which offset any harm to competition and, more broadly, that the restraints resulted in social benefits, particularly an improvement in the quality of dental care.

We note at the outset that the burden of proving sufficient justification for restraints which have been shown substantially to harm competition rests with respondents. Such justifications cannot be speculation only but must be established by record evidence in order to be considered an adequate justification for otherwise anticompetitive behavior. We consider first IFD's argument that its conduct was procompetitive.

As discussed above, a principal device used by IFD for achieving concerted behavior on the part of member dentists was its Work Rule. The Work Rule in part provided:

> The patient's dentist, therefore, has a moral and legal responsibility to not allow a determination

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[14] As for complaint counsel's argument that patients were deprived of information that would lead them to switch dentists, we agree that this is a possible effect of the boycott. Based upon the record, however, we cannot infer an adequately significant effect on competition from this limitation on information. Therefore, we decline to make a finding on this point.

> of his patients [sic] condition to be made for any purpose, without the benefit of a complete examination, which takes into account all of the elements described. (CX 537A)

It is clear from the record that the principal purpose and effect of this Rule was to refuse to provide x-rays to insurance companies that wished to use them along with other information to review claims for reimbursement.

IFD argues that concerted adherence to the Work Rule actually promoted competition among dentists:

> Certainly promoted are novel means of competing concepts of dental care, such as employer or union organized clinics. Competition is naturally promoted among dentists who treat only after total diagnosis, in that their total treatment plan will be more successful from both a preventative viewpoint and long term maintenance of oral health. Error is less likely, thus reducing needed corrective work. Proper diagnosis will promote proper services, and satisfied patients will patronize those dentists. (RAB 24-25)

As to IFD's proposition that "novel means of competing concepts of dental care" are promoted, this is simply unsupported by the evidence. IFD has pointed to no record evidence, or even to any logical argument, suggesting that the Work Rule was in any way necessary to promote "total treatment plans" or any other novel form of dental care. Rather, individual dentists were free to offer such plans or not, just as they would have been in the absence of the Work Rule. Respondent's essential point appears to be simply that such plans were *permitted* by the Work Rule. While this may well be true, it hardly constitutes a showing that the Rule was necessary to achieve some competitive benefit that would have compensated for the Rule's anticompetitive effect.

A similar flaw defeats IFD's second proffered justification, that the Work Rule promoted higher quality care and more satisfied patients. The heart of this position seems to be the contention that the Rule promoted the health of the people of Indiana by preventing insurance companies from reaching erroneous conclusions regarding the least expensive adequate course of treatment for dental patients.[15] Such erroneous conclusions would, the argument goes, cause insurance companies to deny claims for adequate treatment and thereby pressure patients, and through them their dentists, to opt for less than adequate treatment. Two practices of insurers could lead, in IFD's view, to erroneous claims determinations: (1) undue reliance on x-rays, particularly due to the failure to examine the patient personally, and (2) the examination of x-rays by non-dentists.

These contentions, too, are lacking in any evidentiary support. IFD has not pointed to any evidence—or even argued—that any consumers have in fact been harmed by alternative benefits determinations, or that actual determinations have been medically erroneous. Not a single instance has been cited where any dentist agreed to provide less-than-adequate

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[15] There is evidence that some members of IFD objected to the fundamental policy of insurers of covering only the least expensive adequate course of treatment, preferring dental coverage for the "best" treatment that could be provided the patient. However, respondent has not sought to justify its actions on the ground that such a policy is harmful, and this does not appear to have been an official position of IFD.

treatment because of the fear of an erroneous insurance determination. Indeed, with respect to the examination of x-rays by non-dentists, the record shows that non-dentists are authorized by insurers only to *approve* claims; determinations which deny payment must be made by a dental consultant. (ID 158-61) Consequently, it is difficult to understand how patients could even possibly be harmed by the insurers' use of non-dentists.[16]

Moreover, the courts have properly shown great hesitancy in accepting such justifications for clearly anticompetitive acts. In *National Society of Professional Engineers*,[17] the Supreme Court announced that a rule of reason analysis is confined to an assessment of effects on competition and necessarily excludes a justification that other social values which may be advanced outweigh the loss of competition. In that case, the petitioners, a society of professionals selling engineering services, had argued that competitive bidding by the society members would be dangerous to the public health by reducing the quality of services provided. The Court rejected this type of justification on the basis that "the Rule of Reason does not support a defense based upon the assumption that competition itself is unreasonable." [18]

The Court's decisions have not completely clarified this distinction between effects on competition, which

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[16] Respondent's primary argument regarding the screening of x-rays by lay persons, that it violates state law, will be discussed in Part V of this Opinion in connection with the state action defense.

[17] National Society of Professional Engineers v. U.S., 435 U.S. 679 (1978).

[18] *Id.* at 696.

should properly be considered under the rule of reason, and other effects which should not be considered. One factor in making this distinction is whether the challenged conduct amounts to a clear attempt to substitute a private association's judgment about the benefits of competition for a Congressionally-expressed preference in favor of it. This was the case in *Professional Engineers*, where a private association argued that competition itself was undesirable because it led, in that industry, to poor quality—a proposition the Court was unwilling to accept.

In other cases, challenged restraints have limited competition in certain ways only to increase it in other ways, for example, by creating a new product to be offered. This was the case in *Broadcast Music*, where the Court held the rule of reason applicable to a blanket licensing scheme which necessarily fixed the prices among competing composers. Similarly, restrictions on the timing of transactions have been upheld as contributing to the efficiency of organized markets.[19] Thus, an agreement by competing health professionals to allocate admitting privileges at a hospital facility to avoid overcrowding and improve efficient use of the facility could be assessed under a rule of reason.

A third category of cases involves restraints which are clearly intended to achieve an end other than a limitation on competition and in which the effect on competition is at most incidental, in light of the actual purpose of the restraint. For example, sanctions of athletes for gambling in professional sports com-

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[19] Chicago Board of Trade v. United States, 246 U.S. 231 (1918).

petition have been upheld.[20] Thus, guidelines promulgated by a professional health association recommending the avoidance of a drug discovered to be dangerous could not be considered an antitrust violation in the absence of any purpose to limit competition. Similar results have been reached where boycotts are clearly political in nature and are not aimed at competitors.[21] As in the application of any legal standard, some situations will present difficult factual questions as to the effect on competition and the true purpose of the restraint. Moreover, some cases will call for the exercise of sound prosecutorial discretion by the Commission in considering how noncompetitive values relate to the nature of the restraint and the rule of reason analysis set out in *Professional Engineers*.

Fortunately, we need not resolve all these questions here. Even when self-regulation may have been necessary for some legitimate purpose, the courts have insisted that the restraints go no further than is necessary to achieve the desired goal.[22] We applied this principle in our *AMA* decision, where we reviewed a professional association's ethical restrictions on price advertising and price competition. We found that an absolute ban on advertising, including nondeceptive advertising, lessened rather than promoted

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[20] Deeson v. Professional Golfers' Ass'n, 358 F.2d 165 (9th Cir. 1966), *cert. denied*, 385 U.S. 846 (1966); Molinas v. National Basketball Ass'n, 190 F. Supp. 241 (S.D.N.Y. 1961).

[21] *See* Missouri v. N.O.W., 620 F.2d 1301 (8th Cir.), *cert. denied*, 449 U.S. 842 (1980).

[22] See e.g., Silver v. New York Stock Exchange, 373 U.S. 341 (1963); Radiant Burners, Inc. v. Peoples Gas Light & Coke Co., 364 U.S. 656 (1961).

competition, and that the restrictions were much broader than necessary to accomplish the legitimate, pro-competitive goal of preventing deceptive advertising. 94 FTC at 1010.

A fortiori, when self-regulation is not actually necessary for any legitimate purpose and has clear anticompetitive effects, the courts have not hesitated to strike down the restraints. For example, in *American Medical Ass'n* v. *United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943), an association of physicians attempted to induce hospitals not to deal with doctors who participated in prepaid medical programs. The association argued that its concerted behavior was justified because, in its view, these programs were contrary to the public interest and participation in them was unethical. The Supreme Court refused to review the finding of the court of appeals that this conduct harmed competition and that there were alternative methods by which the association could advance its views about alternative delivery systems.[24] 317 U.S. 613 (1943).

The restraint involved here falls squarely into this category of cases. IFD's concerted refusal to furnish x-rays to third-party payers substantially harmed competition among dentists by eliminating incentives for individual dentists to cooperate with cost-containment programs of third-party payers. This refusal to deal reduced consumer choice and impaired insurance companies' ability to conduct cost-containment programs. IFD has presented no evidence to even suggest that these restraints were

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[23] See also Michigan State Medical Society, Docket No. 9129, where we addressed similar issues and reached a similar result.

necessary to serve any legitimate, pro-competitive purpose. There is no basis for concluding that IFD's concerted refusal to deal encouraged development of new methods of care delivery or otherwise encouraged competition among individual dentists. We therefore find that IFD's conduct constituted an unfair method of competition in violation of Section 5 of the FTC Act.

The complaint also alleged that the activities of respondent were "unfair acts or practices" within the meaning of Section 5 as well as unfair methods of competition. It is clear that practices *may* be both unfair methods of competition and unfair practices. For example, in *AMA*, 94 F.T.C. at 1010, we found that AMA's restrictions on price advertising were unfair because they impeded the flow of information about the availability and price of medical services to consumers.

In determining whether a practice is unfair, we are concerned primarily with its impact on consumers, principally individuals purchasing a product or service for their own consumption or investment. In brief, consumer injury that is substantial, not reasonably avoidable, and not outweighed by offsetting benefits to competition or consumers is the primary criterion for a finding of unfairness. (See Commission Statement of Policy on the Scope of the Consumer Unfairness Jurisdiction, December 1980.) In addition, the Commission also relies where possible upon established public policy in determining which practices are unfair. *Id.*

The record in this case contains some evidence of consumer injury in the form of denied or delayed reimbursement for dental care expenditures. However, neither the parties nor the ALJ have analyzed the issue of unfairness liability to any degree. Because our finding of an unfair method of competition in this case is sufficient to support the relief ordered, we decline to decide whether the challenged practices are also unfair.

V. STATE ACTION

Respondent and intervenor, the State of Indiana, adopting Part IV. D. of respondent's appeal brief as its own, assert that the state action doctrine forecloses antitrust liability for the alleged anticompetitive conduct, citing the development of the caselaw in *Parker* v. *Brown*, 317 U.S. 341 (1943), *Asheville Tobacco Board of Trade, Inc.* v. *FTC*, 263 F.2d 502 (4th Cir. 1959),[24] *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (1976), and *City of Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389 (1978). That doctrine exempts from federal antitrust law certain state action and actively supervised private action undertaken pursuant to a "clearly articulated and affirmatively expressed" state policy that consciously rejects unrestrained competition in favor of other social values. *New Motor Vehicle Bd. of Calif.* v. *Orrin W. Fox Co.*, 439 U.S. 96, 107 (1978); *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

Respondent asserts that the Indiana Dental Law (Indiana Code 25-14-1-1 et seq.), which prohibits the unlicensed practice of dentistry, clearly prohibits

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[24] In this case, the court of appeals applied the state action doctrine to the enforcement of the FTC Act. While all Supreme Court interpretations of the doctrine have concerned the Sherman Act, we assume for purposes of this decision that the doctrine applies equally to an enforcement action under the FTC Act, when the allegation of unfair methods of competition is based on Sherman Act principles.

the lay screening of dental x-rays by employees of dental insurers.[25] By virtue of this prohibition, the argument continues, the collective private actions of IFD and its members to frustrate the lay screening of x-rays is protected from liability under the antitrust laws.

As discussed further below, respondent's "state action" argument fails in several respects. First, and most fundamentally, the Indiana law does not af-

[25] The law provides in pertinent part:

> Sec. 23. Any person shall be said to be practicing dentistry within the meaning of this chapter who uses the word "dentist" or "dental surgeon" or the letters "D.D.S." or "D.M.D." or other letters or titles in connection with dentistry:
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> or owns or operates a dental office or is manager or conductor of the same;
>
> or advertises or permits to be advertised by sign, card, circular, handbill, newspaper, radio, or otherwise that he can or will attempt to perform dental operations of any kind;
>
> or offers to diagnose or professes to diagnose or treats or professes to treat any of the lesions or diseases of the human oral cavity, teeth, gums, maxillary or mandibular structures;
>
> or extracts human teeth or corrects malpositions of the teeth or jaws;
>
> or administers dental anesthetics, whether local or general;
>
> or makes x-rays pictures of the human teeth or jaws;
>
> or makes impressions or casts of any oral tissues or structures for the purpose of diagnosis or treatment thereof or the construction, repair, reproduction or duplication of any prosthetic device to alleviate or cure any oral lesion or replace any lost oral structures, tissue, or teeth;
>
> or engaged [sic] in practices included in the curricula of recognized dental colleges * * *.

firmatively express any policy in favor of collusion among dentists in order to prevent or influence the use of x-rays by insurance companies. Respondent, in fact, does not appear to argue that the State of Indiana has expressed a policy against competition among dentists, which must be the principal concern of a "state action" analysis. Second, it is far from clear that the Indiana statute prohibits lay persons from reading x-rays for purposes of screening dental insurance claims, as opposed to determining treatment. Finally, respondent has not shown that its conduct, which essentially amounted to private enforcement of this state statute, was supervised by state authorities. We discuss each of these points in turn.

Assuming for a moment that the Indiana statute does prohibit lay persons from reading x-rays and that "dentists who knowingly [sic] submit radiographs (x-rays), or other diagnostic data to third persons, including insurance companies that allow lay persons other than licensed dentists to review such data, are aiding and abetting the unlawful practice of dentistry" (RAB 46) such a "state policy to supplant competition" (RAB 39) between dentists and non-dentists is insufficient to protect the activities at issue in this case. This case concerns concerted actions among dentists regarding their dealings with dental insurers; and the Indiana legislature did not compel, authorize, or even contemplate private agreements among dentists not to cooperate with dental insurers that might be using lay persons to read x-rays—or other concerted efforts to influence the business practices of insurers. There simply is no "clearly articulated and affirmatively expressed" state policy concerning such elimination of competition among dentists in their dealings with insurers.

Respondent argues that "the Indiana dentists who choose to obey Indiana Dental Law cannot be in violation of antitrust law." (RAB 48) But this is not a case of individual dentists simply conforming their conduct to state law.[26] Apparently, respondent would have us conclude that Congress intended for federal antitrust laws to give way when private parties, by conduct which would otherwise violate the antitrust laws, take it upon themselves to enforce their interpretation of the provisions of any state law. No Supreme Court decision articulating the state action doctrine can be read to endorse such an interpretation of congressional intent.

Furthermore, we cannot accept respondent's contention that Indiana law clearly prohibits the screening of x-rays by lay employees of insurers for the narrow purpose of referring questionable claims to dental consultants. The Indiana statute does not specifically address such conduct (although it does prohibit lay persons from taking x-rays), and the state has never sought to enforce the statute against insurers that use non-dentists in such a way. Indeed, on August 15, 1978, IFD brought suit against the state and the Indiana State Board of Dental Examiners alleging that they had "wholly failed, refused, or neglected to take any action to enforce the laws of the State of Indiana" as interpreted by

[26] Indeed, Indiana state law seems actually to have little to do with the activities charged here. Neither IDA's Principles of Acceptability nor IFD's Work Rule concerned *who* at insurance companies should or should not read x-rays. The focus of these policies and the activities of IDA and IFD was, rather, the notion that x-rays should not be used in any manner without a personal examination of the patient. We can determine no way in which the challenged conduct was logically directed toward compliance with state law.

IFD.[27] (CX 508A, D) Therefore, the applicability of the statutory prohibition on the unlicensed "practice of dentistry" to such a situation has not been considered by the Indiana Courts. In Pennsylvania, however, a very similar statute has been held not to prohibit a first review of radiographs by a lay clerk to determine whether they satisfy Blue Shield standards. *Pennsylvania Dental Ass'n* v. *Comm. Ins. Dept.*, 398 A.2d 729, 734 (Pa. Cmwlth. 1979).[28] Furthermore, an Illinois appellate court has held that even as performed by a dentist, the act of "merely corroborating the claim presented [by reading an x-ray provided to an insurer] so as to know whether or not payment of the cost thereof should be made" is not the practice of dentistry. *Pfluger* v. *Sundstrand Corp.*, 405 N.E.2d 12, 16 (Ill. App. 1980). Particularly in light of these opinions, it cannot be concluded that there is a "clearly articulated and affirmatively expressed" state policy concerning such conduct.[29]

[27] The suit against the state and the board was dropped when the state agreed to intervene in this case. (ID 183)

[28] The Pennsylvania statute provides:

> "A person engages in the 'Practice of Dentistry,' within the meaning of this act, who diagnoses, treats, operates on, or prescribes for any disease, pain or injury, or regulates any deformity or physical condition of the human teeth, jaws, or associated structures, or conducts a physical evaluation, or administers anesthetic agents, or who fits, constructs, and inserts any artificial appliance, plate, or denture for the human teeth or jaws, or who holds himself or herself out as being able or legally authorized to do so." 63 P.S. § 121, as quoted by the court at 398 A.2d 734 n.4.

[29] Respondent has argued that in addition to constituting an unlawful diagnosis, the reading of x-rays by insurance com-

In furtherance of its state action argument, respondent has pointed to the issuance of a 1974 unofficial advisory letter of the Deputy Attorney General of Indiana (IX-5), various bulletins or letters subsequently issued by the State Board of Dental Examiners (e.g., IX 6, IX 9), and a joint letter issued by the State Board and the Insurance Commissioner on September 24, 1979 (IX 162). In all of these documents, the Indiana Dental Law is interpreted as prohibiting the screening of dental x-rays by lay persons.[30] However, as the ALJ has explained, none of these documents constitute action

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pany employees also violates a provision of the dental code that includes in the definition of the practice of dentistry "practices included in the curricula of recognized dental colleges." Indiana Code 25-14-1-23. Radiology is a required subject in the curricula of state dental schools. 828 Indiana Administrative Code 1-1-1(c) (1979 Ed.). Therefore, respondent argues, the reading of x-rays by unlicensed persons violates the statute.

Bacteriology, anesthesia, pathology, and "medicine" are also subjects required to be taught in the dental schools. Yet, surely respondent would not suggest that they are the exclusive domain of dentists. Indeed, as the Supreme Court of Indiana has held, "practices included in the curricula" does not refer to *subjects* taught in dental colleges "but to those things which are *practiced as provided* in the curricula, which evidently mean the things practiced *in the dental clinic*, such as, operative prosthetic dentistry, crown and bridge work, inlay, and orthodontia." (emphasis added) *State* v. *Williams*, 5 N.E.2d 961 (Ind. 1937). This provision of the statute therefore, is of little independent significance.

[30] We note that all of these documents postdate some of IDA's activities in furtherance of the IDA-IFD conspiracy—most notably its 1973 pledge drive for support of its Principles of Acceptability.

of the state acting as sovereign, since none was developed according to the applicable requirements of the Indiana Administrative Procedure Act. (ID 152-153, 167-181)[31] Respondent has apparently conceded this point and has argued not that these documents establish the state policy regarding the screening of x-rays, or even that they constitute some evidence of the state policy, but rather that they evidence "state supervision of the scheme chosen to replace the rules of the market place." (RAB 39)

Conduct by private parties that would otherwise violate the antitrust laws is not immunized by the state action doctrine unless the activity is "actively supervised" by the state. *California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. at 105. Because respondent did not address the question of whether its *concerted* activities were compelled or authorized by a clearly articulated state policy, it also did not consider whether those activities were actively supervised by the state. Instead, it pursued the misguided argument that the practice of dentistry by *individual* dentists in Indiana was being supervised adequately by the state, through the State Board of Dental Examiners. We need not consider the issue of supervision in this case in any event, because respondent has not satisfied the requirement of establishing a clearly articulated state policy regarding the challenged conduct.

In addition to supporting respondent's state action arguments, intervenor asserts that in this case the Commission "is clearly attempting to invade the State's sovereign right pursuant to the Tenth Amend-

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[31] Since this is the case, we need not consider whether the state board is authorized to promulgate substantive regulations defining the practice of dentistry.

ment" to regulate the practice of dentistry in Indiana. (IAB 7-8) However, as the above discussion reveals, the authority of the state of Indiana has not been questioned by the Commission in this case. The Commission has not questioned the validity of the Indiana Dental Law or the manner in which it has been enforced by the state. The sole focus of this case is the concerted private actions of IDA, IFD, and their members—actions in no way compelled or expressly contemplated by Indiana law. Furthermore, the Commission's Order against respondent will not interfere with the state's enforcement of the Dental Law, even if it should seek to enforce the interpretation of it asserted in this proceeding. The Order does not compel any dentist to cooperate with an insurance company that uses lay persons to screen dental x-rays, nor does it give any form of protection to or approve of such a screening procedure. Therefore, the Commission's order does not impinge on the ability of the state of Indiana, acting as sovereign, to regulate the practice of dentistry in the manner the state sees fit.

VI. COLLATERAL ESTOPPEL

On July 17, 1979, the Commission was ordered by Judge Cale J. Holder, United States District Court, Southern District of Indiana, to allow the State of Indiana to intervene in this proceeding. (IX 1000U) (The background on this order, which the Commission did not appeal, is explained in the Initial Decision, findings 191-207.) Respondent and intervenor, adopting Part IV.E. of respondent's brief as its own, assert that various of Judge Holder's findings of fact and conclusions of law foreclose the Commission from "further litigation of the state action issue." (R49)

Respondent claims that the following "findings of fact" by the judge are pertinent:

> 2. Plaintiff Indiana State Board of Dental Examiners (hereinafter Board), pursuant to I.C. 25-14-1-1 *et seq.*, has been granted the duty and power by the Indiana General Assembly to administer, supervise and enforce the Indiana Dental Act—which provides for the regulation of dentists and the practice of dentistry within the State.
>
> 6. Since at least 1887 the State of Indiana, pursuant to the police power reserved to it as a sovereign state, has had legislation regulating dentists and the practice of dentistry.
>
> 17. The State of Indiana has and is, actively regulating both dentists and the practice of dentistry in the State.
>
> 18. Under the mandate of Indiana Law, Indiana dentists are prohibited from submitting their dental X-rays to third party insurers who employ "dental consultants," who are not licensed to practice dentistry, to read or diagnois [sic] the X-rays. (IX 1000Z5, 6, 9)

Respondent also relies on these conclusions of law:

> 3. The order proposed by the Secretary of the F.T.C. would infringe on the State's right to regulate the practice of dentistry within the State as reserved to the State under its police powers by the Tenth Amendment to the Constitution of the United States. *Linder v. United States*, 268 U.S. 5 (1925). *F.T.C. v. Simeon Management Corp.*, 391 F. Supp. 697, 705 (N.D.

Cal., 1975) *aff'd* 532 F.2d 708. *Cf. National League of Cities v. Usery*, 426 U.S. 833 (1976).

6. The F.T.C. is proceeding beyond its jurisdiction in attempting to regulate the practice of dentistry in the State of Indiana and should be enjoined from doing so. *Leedom v. Kyne*, 358 U.S. 184 (1958). *Jewel Cos. v. Federal Trade Comm.*, 432 F.2d 1155 (7th Cir., 1970). (IX 1000Z10)

Contrary to respondent's assertion, these findings, even assuming the doctrine of collateral estoppel applied, would not preclude the Commission from considering here whether the state action doctrine protects respondent's conduct. The court did not consider all of the elements of the state action doctrine; nor did it purport to do so.[32] Assuming the Commission were bound by the court's" factual" finding #18, respondent's state action defense would still be defeated by the fact that its actions were not compelled or expressly contemplated by Indiana law—they were purely private conduct. As to the court's legal conclusions, they do not appear to have any relevance to a state action analysis. Rather, they pertain to the Commission's jurisdiction in this case in light of the state's purportedly exclusive powers to regulate the practice of dentistry in Indiana.

Furthermore, we concur with the ALJ's finding that the court's determinations were not essential to the judgment ordered; consequently, the doctrine of

[32] Indeed, it would have been premature for the court to rule on the applicability of the state action doctrine to this case before the conclusion of the administrative proceeding. California ex rel. Christensen v. FTC, 549 F.2d 1321 (9th Cir.), *cert. denied*, 434 U.S. 876 (1977).

collateral estoppel does not apply here.[33] When Judge Holder ordered the Commission to allow the State of Indiana to intervene in this proceeding, he adopted *in toto* the state's proposed findings. See IX 1000Z5-10 and CX 853 A-G) However, these findings had been offered in support not only of the proposed order ultimately granted by the judge, but also of an order directing the Commission to terminate this proceeding. Obviously, many findings necessary to support the latter order would not be necessary to support the former. Legal conclusions #3 and #6 appear to be two such findings, since they deal with the Commission's jurisdiction. Indeed, it would seem that these conclusions would have compelled the judge to order this proceeding terminated. Thus, we believe that these conclusions were not essential to the judgment entered. The court's conclusion of law #5 would seem to have been sufficient:

5. The State meets the requirements for intervention as established by the FTC in the [sic] *Firestone Tire and Rubber Company*, Dkt 8818, 77 F.T.C. 1666, 1669 (1970) in that *the issues the State seeks to raise* cannot be properly raised

[33] It is beyond dispute that an issue must have been decided necessarily in a first action in order for reconsideration of that issue to be barred in a second proceeding. Cromwell v. County of Sac, 94 U.S. 351, 354 (1876) : Haize v. Hanover Ins. Co., 536 F.2d 576, 579 (3d Cir. 1976). "When an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination *is essential* to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim." (emphasis added) Restatement, Second, Judgments § 27 (1982).

> and argued by the current parties to the proceeding and only minimal additional cost and time will be required by its intervention. (emphasis added) (IX 1000 Z10)

We agree with complaint counsel that it would be anomalous for the court to have ordered the State of Indiana's intervention, if it intended to foreclose any argument on the issues the State sought to raise. We also agree that the Commission is not required to accept the court's subsequent characterization of all of its findings as necessary for the relief sought,[34] when our own analysis compels its rejection. *Hartmann* v. *Time, Inc.*, 166 F.2d 127, 138 n.17 (3d Cir.), *cert. denied*, 334 U.S. 838 (1948).

VII. ORDER

The ALJ entered an order against IFD, dissolving it as an entity, and against the members of IFD, prohibiting them from collectively refusing to submit x-rays or deal with anyone to "force their will on the target of such boycott." Complaint counsel did not propose an order dissolving IFD as an organization but did propose additional provisions, including a more general ban on coercion of dental insurers, a prohibition on attempting to influence consumers' choice of dentists based upon the dentist's cooperation with insurers, and a ban on coercing the insurer's

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[34] The court stated on October 18, 1979, that the Commission "is unhampered by this Court's ruling of August 17, 1979 in fulfilling its mission in Docket No. 9118." But it added, "The findings of fact as found and the conclusions of law thereon are necessary for the relief sought." (IX 1000E-F) The full text of the October 18 order appears on pp. 124-25 of the Initial Decision.

choice of dental consultants or the consultant's judgment.

We decline to accept the ALJ's conclusion that an order dissolving IFD is necessary. It is true that the courts have upheld dissolution of organizational entities where they have been principally designed to implement an antitrust violation and where dissolution was the most effective way of preventing the recurrence of the violation.[35] We also agree with the ALJ that IFD was created primarily to continue the implementation of IDA's boycott of dental insurers. However, we note that IFD's constitution and bylaws contain objectives other than coercing dental insurers. Moreover, there are certainly legitimate functions its members may wish to pursue through the vehicle of a special organization such as IFD. Consequently, we believe it is adequate to ban specific activities of IFD and to rely upon compliance with the terms of these restrictions, in order to prevent a recurrence of antitrust violations and to restore competition to the dental market.[36] Only in circumstances where there is no significant function remaining for an organization other than to repeat antitrust violations, or in which a conduct order would not reasonably be expected to prevent repeating such violations or to restore competition, would a dissolution order be appropriate.

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[35] Los Angeles Meat & Provision Drivers Union v. United States, 371 U.S. 94, 98, 103 (1962); Hartford-Empire Co. v. United States, 323 U.S. 386, 428 (1945).

[36] We take no position on the circumstances under which IFD might qualify as a "labor organization," except to note that respondent did not pursue or appeal the argument that its conduct was entitled to immunity from the antitrust laws under the "labor exemption."

Our prior orders in analogous situations [37] have been intended principally to bar collective action by dentists which results in coercion of dental insurers in regard to the dentist-insurer relationship. Here, the principal anticompetitive result of IFD's conduct was to achieve a uniformity among its members in their dealings with insurers, i.e., a concerted refusal to provide x-rays for claims review, thus disrupting insurers' cost-containment programs. More generally, respondent coerced these companies into operating in a certain way. Thus, we include provisions prohibiting activities which have the purpose or effect of collective refusals to submit x-rays or more generally to coerce insurers or their employees to behave in a certain way. This latter provision would necessarily include insurers' choice of consultants and insurers' influencing consultants. This provision would not, however, prevent noncoercive communications between IFD and insurers regarding the manner in which insurers conduct their business. IFD remains free to urge third party payers to adopt or abandon certain practices, so long as it does so in a noncoercive way and avoids suggesting to its members that they refuse to cooperate with those payers that reject its advice.

We also include a provision prohibiting IFD from collectively attempting to influence patients not to choose particular dentists. This provision is justified on the basis of an incident in the record where a person acting for the benefit of IFD did influence a patient group directly by persuading an employer to stop listing dentists who cooperated with third-party payers (see CX 563B), as well as on the basis

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[37] See Indiana Dental Ass'n, 93 F.T.C. 392 (1979); Texas Dental Association, Docket No. 9139 (Nov. 19, 1982).

that this is a fencing-in provision which prohibits IFD from coercing insurers indirectly through influencing patient behavior. As such, it is reasonably related to the unlawful practices.[38]

In order to make it clear that the order does not apply to dentists acting individually, we have provided that individual dentists may deal with insurers in the way each sees fit. We have also provided that this order does not prohibit IFD from adopting *bona fide* guidelines concerning the exposure of patients to radiation. IFD has not claimed that any of its activities challenged here were prompted by a concern that complying with the requests of third-party payers would expose dental patients to unnecessary radiation. What little evidence there is in the record indicates that the payers in Indiana request only x-rays that are necessary for diagnosis of the patient's condition and determination of an appropriate course of treatment, i.e., x-rays that would normally be taken by the patient's dentist as part of good dental care.[39] Nevertheless, in order to avoid any misunderstanding as to the subject of this case or apprehension over the meaning of the order as it pertains to this issue, we have included a specific provision on this point.[40]

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[38] *See* Jacob Siegel Co. v. FTC, 327 U.S. 608, 612-13 (1946); Litton Industries v. FTC, 676 F.2d 364, 370-71 (9th Cir. 1982); Sears Roebuck & Co. v. FTC, 676 F.2d 385, 391-92 (9th Cir. 1982); American Home Products Corp. v. FTC, No. 81-2930, slip op. at 45-50 (3rd Cir. Dec. 3, 1982).

[39] Testimony of Connecticut General employee Chichester, Tr. 396-97, 563-64.

[40] A misunderstanding of the proposed consent order in the Texas Dental Association case, Docket 9139 (Nov. 19, 1982), caused the Deputy Commissioner of the Food and Drug Ad-

Finally, we include notification and reporting requirements to insure that individual IFD members are aware of the Order and that the Commission may monitor respondent's compliance with other order provisions.

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ministration to file a concerned public comment. He read the order in that case to require dentists to submit x-rays requested by insurers, even if that would mean exposing the patient to needless radiation. FDA's fears were relieved by the Commission's assurance that the order applies only to x-rays that already exist, and it does not prohibit the association from adopting professional standards concerning the appropriateness of taking x-rays. 47 Fed. Reg. 52993 (Nov. 24, 1982). Furthermore, neither that order nor the one we are issuing today pertains to the actions of dentists acting individually.

UNITED STATES OF AMERICA
BEFORE THE
FEDERAL TRADE COMMISSION

Commissioners: James C. Miller III, Chairman
David A. Clanton
Michael Pertschuk
Patricia P. Bailey
George W. Douglas

Docket No. 9118

IN THE MATTER OF

INDIANA FEDERATION OF DENTISTS,
a unincorporated association

ORDER DENYING PETITION FOR RECONSIDERATION

On February 21, 1983, the Commission issued its decision and final order in this matter. On March 11, 1983, respondent filed a petition for reconsideration under Rule 3.55 of the Commission's Rules of Practice. Respondent argues that a regulation promulgated by the Indiana State Board of Dental Examiners on May 8, 1982, "conflicts with the mandates of the Commission's recent Order . . . [and] compels reconsideration of the Commission's rejection of the state action exemption." (Petition at pp. 6-7)

Any petition filed under Rule 3.55 "must be confined to new questions raised by the decision or final

order and upon which the petitioner had no opportunity to argue before the Commission." Since respondent made no effort to apprise the Commission of the state regulation before the Commission issued its decision and order, respondent is now hard pressed to argue that the order raises questions upon which it had no earlier opportunity to argue before the Commission. Nevertheless, the Commission has considered respondent's petition on the merits and found it unpersuasive.

The regulation provides in relevant part: "Any person using dental diagnostic materials for the purpose of recommending changes in the treatment plan upon which [reimbursements by a third party] are based is practicing dentistry and must be a dentist. Indiana dentists shall not knowingly submit dental diagnostic materials to any party involved in the Unauthorized Practice of Dentistry." 828 IAC 1-4 (Indiana Register, Vol. 5 Number 5, pp. 992-3, May 1, 1982). Clearly this regulation has no relevance to respondent's state action defense in this case, which concerns conduct engaged in by respondent only up to the time the record was closed in 1979. A regulation promulgated in 1982 cannot, as complaint counsel note, retroactively immunize prior unlawful conduct. Furthermore, even if the regulation had been in effect during the relevant time period, it would not have compelled the concerted action in which respondent engaged. Respondent asserts that the use of the plural word "dentists" in the regulation must mean that Indiana dentists are required to comply *as a group* and, consequently, must conspire together to enforce the regulation among their fellows. This creative analysis exceeds the bounds of reasonableness.

Contrary to respondent's assertion, the opinion in *Gambrel* v. *Kentucky Board of Dentistry*, 689 F.2d 612 (6th Cir. 1982), is not instructive in this matter. *Gambrel* concerned a state board of dentistry's interpretation of a state statute as forbidding dentists from providing prescriptions for dentures directly to consumers. The court upheld the decision in this private suit that the state board's enforcement activity and the *individual* conduct of dentists subject to the statute were protected by the state action doctrine. In *Gambrel* there was no evidence of collective behavior by dentists. 689 F.2d at 20.

Respondent asserts that the Commission's order "would place Indiana dentists in a position of choosing between compliance with the new dental regulation, and compliance with the Order." (Petition at p. 17) However, the Commission's order plainly pertains only to activity engaged in by the Indiana Federation of Dentists or a successor organization, acting as an organization, or by its officers or representatives, acting on behalf of the organization. The individual conduct of IFD members is expressly excluded from the order. The order does not even govern the collective conduct of some IFD members, so long as that conduct is not performed by or on behalf of the federation or a successor organization. (However, such concerted conduct might constitute an unfair method of competition subject to challenge under the Federal Trade Commission Act.) Respondent is correct in interpreting the order to prohibit IFD from adopting a policy against the submission of x-rays or other materials to third-party payers or from "coercing any third-party payer to operate or deal in any particular way." (Petition at p. 21) But since the order deals only with collective con-

duct, and the state regulation concerns only individual conduct, there is no conflict between the two.

Furthermore, the evidence in the record of the Commission's proceeding indicates that none of the targets of respondent's boycott were involved in the unauthorized practice of dentistry as now prohibited by the state regulation. The regulation provides: "Any person using dental diagnostic materials for the purpose of recommending changes in the treatment plan upon which [third party] benefits are based is practicing dentistry and must be a dentist." 828 IAC 1-4-2. Contrary to respondent's assertion, the record does not demonstrate that changes in treatment are recommended by non-dentist employees of dental insurers in Indiana. Rather, all the evidence indicates that lay employees of insurers can only approve claims for reimbursement or refer them to a dental consultant for evaluation.

Respondent has also argued that the order is unclear and overbroad. Since the language to which respondent refers was contained in the draft order accompanying complaint counsel's answering brief, it is not a matter upon which respondent can claim to have had no previous opportunity to argue. Nevertheless, the Commission has considered respondent's concerns and concluded that its fears are unfounded.

Respondent states that it is unclear whether officers and representatives of IFD are prohibited from engaging on an individual basis in conduct forbidden to IFD. Officers and representatives of IFD are members of that organization. Since the conduct of IFD members acting individually is expressly excluded from the order's effect, it follows *a fortiori* that the prohibition on conduct by "respondent . . . and its officers and representatives" refers only to conduct by or *on behalf* of IFD.

Respondent's other concern is that the order may preclude IFD from lobbying or encouraging the Indiana Board of Dental Examiners to take action that "may result in the effect proscribed by the Commission's Order." (Petition, p. 24) However, any effort by the Commission to preclude a respondent from exercising its First Amendment rights would be constitutionally impermissible. Therefore, the only reasonable interpretation of the order is that the Commission did not intend, in prohibiting conduct that might have the "effect" of requiring that dentists not submit requested materials to third-party payers, to prohibit IFD from engaging in activities that are protected by the Noerr-Pennington doctrine.

Respondent may at some future time identify certain conduct in which it may wish to engage as an organization and which it believes is or may be prohibited by the Commission's order. The appropriate course for respondent at that time would be to seek informal advice from compliance staff, to seek an advisory opinion, or to file a request to reopen and modify the order under Rule 2.51. A request for modification must show that a change in the Commission's order is compelled by changed conditions of law or fact or by the public interest.

Accordingly, respondent's petition is hereby denied.

Filed March 24, 1980

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

Docket No. 9118

IN THE MATTER OF

INDIANA FEDERATION OF DENTISTS,
an unincorporated association.

INITIAL DECISION

Paul R. Teetor
Administrative Law Judge

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UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

Docket No. 9118

IN THE MATTER OF

INDIANA FEDERATION OF DENTISTS,
an unincorporated association

INITIAL DECISION

Paul R. Teetor, Administrative Law Judge

L. Barry Costilo, Esq.
M. Elizabeth Gee, Esq.
James McCarty, Esq.
Counsel Supporting the Complaint.

Ronald K. Fowler, Esq.
Counsel for Respondent.

Bruce W. Graham, Esq.
Intervenor for State of Indiana.

SUMMARY OF PROCEEDING

On 10/18/78 the Commission issued its Complaint against the Indiana Federation of Dentists (IFD), a small unincorporated association organized in 1976. The Complaint was served on Indiana Federation Of Dentists at its office at 2403 Raible Avenue in Anderson, Indiana on 11/13/78. The Complaint charged the Federation and its members, in substance, with adopting and pursuing a conspiracy started some years earlier by the much larger Indiana Dental Association (IDA), which was named here as a co-conspirator but not as a Respondent.[1] The conspiracy charged centers about an organized effort to keep Indiana dentists from turning over patients' dental radiographs (commonly called X-rays) to group dental health care insurers. The principal terms of the alleged conspiracy are described in Paragraph 9 as follows:

"A. Promulgated and distributed to their members guidelines and principles for dealing with third-party payers, along with forms and information to facilitate adherence to such guidelines and principles;

B. Encouraged and induced their members to discontinue serving and/or to refuse to serve as dental consultants for third-party payers and to refuse to provide payers with other professional services such as, but not limited to, taking X-rays for use in benefits determination;

[1] At the same time that the Commission issued this complaint it accepted a consent order from IDA in Docket No. C-2957. See Federal Register, Vol. 43, No. 223—Friday, November 7, 1978.

C. Conducted meetings, workshops, and pledge campaigns among their members to gain the agreement of individual members not to compete with other dentists in dealing with third-party payers;

D. Urged dental organizations in other states to pursue courses of conduct similar to that hereinabove described; and

E. Urged payers, purchasers, and beneficiaries of dental health care benefits plans to eliminate provisions of such plans that they find unacceptable."

Paragraph 11 of the Complaint added the following:

"Since September 1976, respondent and its members, in concert and agreement among themselves, have acted in furtherance of the agreement and concert of action alleged in PARAGRAPH NINE, and have otherwise engaged in acts, practices, and methods of competition to eliminate, prevent, or hinder competition among dentists with respect to cooperation with dental health care benefits programs containing predetermination and least expensive course of treatment provisions by, *inter alia*:

A. Promulgating, adopting, publishing, and distributing to its members a purported "work rule" that details certain uniform courses of conduct for dentists in their dealings with third-party payers; and

B. Urging payers, purchasers and beneficiaries of dental health care benefits plans to eliminate provisions of such plans that respondent finds unacceptable."

(The Complaint regularly refers to "third-party payers" rather than "insurers" but we use the term "insurer" as following popular usage more closely.)[2]

The conspiracy is said to have adversely affected competition among Indiana dentists; tended to fix or tamper with the price of dental health care in Indiana; deprived consumers of the benefit of insurers' cost-containment efforts; deprived them, too, of the benefit of a second dentist's opinion on the adequacy of proposed dental treatment; and limited their opportunity to select dentists who cooperate with dental health care benefit plans. The relevant text (Par. 12) reads:

> "The acts, practices and methods of competition alleged in PARAGRAPHS NINE through ELEVEN have had, or have the tendency or capacity to have, among others, the following effects:
>
> A. Competition among dentists in Indiana has been hindered, restrained, foreclosed, and frustrated;
>
> B. The cost of dental health care services in Indiana has been or may be stabilized, fixed, or otherwise tampered with;
>
> C. Consumers have been or may be deprived of the benefit of third-party payers' cost-containing measures, including lower or potentially lower costs for dental health care services and dental health care benefits insurance;

[2] Technically a cost-plus group insurer is probably not an "insurer" because the Supreme Court views the spreading and underwriting of risk as the "primary elements" of insurance. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 211 (1979).

> D. Consumers have been or may be denied the benefits of a second dentist's opinion as to the adequacy of proposed dental treatment; and
>
> E. Consumers have been limited in their opportunity to select dentists who cooperate with dental health care benefits programs."

The acts and practices described in the Complaint are said to constitute both unfair methods of competition and unfair acts and practices and for both reasons to violate Section 5 of the Federal Trade Commission Act. The contemplated relief is an order for Respondent to cease and desist from the following:

> "1. to cease and desist from engaging in any activity that has the purpose or effect of causing or inducing dentists not to cooperate with any third-party payer;
>
> 2. to cease and desist from engaging in any activity which has the purpose or effect of causing or inducing consumers to choose dentists who do not cooperate with third-party payers;
>
> 3. to cease and desist from engaging in any activity that compels or coerces any third-party payer to incorporate, delete, or modify any provision in any existing or proposed dental health care benefits program;
>
> 4. to cease and desist from all activities that have the purpose or effect of influencing the

selection of dental consultants or the opinions rendered by such consultants; and

5. to notify their members and local chapters of the substantive relief provided by the order, including affirmative statements advising members that they are free to make their own decisions concerning cooperation with third-party payers."

On 10/20/78 the matter was assigned for trial to Paul R. Teetor, Administrative Law Judge, and he has since presided over all proceedings. A motion by Respondent for a more definite statement of the charges of the Complaint was denied but Respondent's time to answer was extended to 12/22/78. In its Answer Respondent admitted a few preliminary allegations of the Complaint but denied all important substantive allegations and raised a number of affirmative defenses, including failure to state a claim, state action defense, no effect on interstate commerce, non-profit association, commercial free speech, business of insurance, and complaint contrary to the public interest.

On 12/29/78 the State of Indiana moved to intervene in this proceeding to see that the so-called "state action" defense would be presented adequately. On 1/5/79, however, the Administrative Law Judge, while willing to grant *amicus curiae* status, denied the motion to intervene on the ground that the difficulties of trial would be increased without offsetting value, absent any showing that Respondent would not be able to present the "state action" defense properly.

On 1/9/79 a major prehearing conference was held in Washington at which both sides made opening statements of position, followed by arguments as

to important legal questions involved. A substantial part of the conference was devoted to planning discovery, including Complaint Counsel's need for certain subpoenas and Respondent's demand for inspection and copying of Commission files and its applications for interrogatories to Complaint Counsel and for third-party subpoenas. Complaint Counsel were ordered to turn all their evidence over to Respondent by 5/20/79 and Respondent to turn its evidence over to Complaint Counsel by 6/20/79. Trial was anticipated for the coming summer. Thereafter both sides worked actively and productively on discovery problems through the Spring of 1979.

At the prehearing conference of 1/9/79 Complaint Counsel's objection to searching Commission files as far back as 1961 had been overruled because the Complaint's allegations go that far back. On 2/1/79, however, Complaint Counsel gave notice of their willingness to limit their case to activities from 1970 on and Respondent accordingly agreed on 2/6/79 that the Government's file search might omit documents prepared, sent or received by the Commission prior to 1/1/70. This stipulation was approved by the Administrative Law Judge on 2/8/79.

On 2/5/79 the Commission denied a request for an appeal by the State of Indiana from the Administrative Law Judge's refusal to permit intervention as a party but confirmed that the State might have *amicus curiae* status. Unsatisfied, the State of Indiana on 5/23/79 filed a Complaint (Civ. IP 79-453-C) in the U.S. District Court for Southern Indiana (Indianapolis Division) seeking an injunction against further prosecution of this matter unless and until the State of Indiana be permitted to intervene as a party or, alternatively, an injunction against further

prosecution of this matter under any circumstances (because, the Complaint averred, the "state action" doctrine is applicable here and operates to deprive this Commission of jurisdiction).

On 6/15/79 another prehearing conference was held in Washington, primarily to discuss the practical problems that were arising because of a substitution of counsel for Respondent. A request by Respondent for an additional 90 days to prepare for trial was denied as unnecessary because Respondent's new counsel was its regular lawyer and quite familiar with the facts of the case. Respondent's scheduled turnover of its evidence on 7/20/79 was confirmed and trial was set for 8/6/79. By 7/17/79, however, counsel on both sides felt need for more time and trial was postponed until 9/17/79.

Meanwhile, on 7/19/79 the U.S. District Court for Southern Indiana, Holder, J., conducted a brief trial on affidavits in the State of Indiana's suit against the Commission and on 8/17/79 handed down a decision by mistake granting the State *both* of the alternative judgments it sought. The mistake was corrected almost immediately by the Court by leaving only the judgment of intervention standing but the supporting findings were never altered.

In conformance with Judge Holder's intervention order [3] and in view of the need of the Indiana Attorney General's office for some time to prepare for participation in the trial, the holding of evidentiary hearings in this matter was again postponed. On 8/17/79 the Intervenor was given until 9/24/79 to turn its proposed evidence over to the other parties

[3] The Commission's formal reversal of its 2/5/79 order did not occur until 10/16/79.

and trial was finally set to begin on 10/2/79 in the Federal Courthouse in Indianapolis, Indiana.

Early in the hearings (10/5/79) Complaint Counsel moved, on instructions from the Administrative Law Judge, to amend the Complaint to conform to their proposed proof by including certain theories of interstate commerce not specifically referred to in the Complaint, although literally covered by the words "among other things" in Paragraph 7 of the Complaint. It appearing that Respondent and Intervenor had been on notice for several weeks before trial that Complaint Counsel proposed to add the evidence in question to their proof of interstate commerce, the Judge, while doubting need for the amendment, proceeded to grant it purely as a precautionary matter in open court on 10/9/79.[4]

Complaint Counsel's case-in-chief was presented by 17 witnesses, largely insurance company dentists and administrators, between 10/2/79 and 10/17/79. Respondent's Defense was presented by 4 witnesses, largely Respondent's organizers and officials, on 10/30/79. Intervenor's case was presented by four witnesses, including two academic experts in dentistry, on 10/29/79 and 11/1/79. Complaint Counsel's sole rebuttal witness, an official of the Indiana Department of Insurance, was heard on 11/1/79. It was understood by all parties that if for any reason the State's status as an Intervenor were eventually disapproved, nonetheless the testimony adduced by it would remain in the record and would be treated as if adduced by Respondent. A List of Witnesses follows.

[4] TR 1058.

List of Witnesses

Witness	Address	Sponsor	Dates/ Testimony	Page References
Anderson, Carlton	28 Park Avenue Cadwell, N.J. 07006	Complaint Counsel	October 16, 1979	1976-1991
Arvanitis, Ernest A.	25-11, 147 Flushing St. Flushing, N.Y.	Complaint Counsel	October 16, 1979	1930-1949
Chichester, David I.	14 Ridge Road Enfield, Conn.	Complaint Counsel	October 3-4, 1979	387-626
Christianson, Steven	1984 Stoneyhill Drive Hudson, Ohio	Complaint Counsel	October 12, 1979	1609-1648
Clegg, Robert L., III	Indiana State Insurance Department	Complaint Counsel	November 1, 1979	2762-2784
Dixie, Gene F.	1235 Mission Street San Francisco, Cal.	Complaint Counsel	October 2, 1979	250-349
Downes, William G., DDS	Newington, Conn.	Complaint Counsel	October 10, 1979	1212-1394
Hurwitz, Jacob	21760 Kenosha Oak Park, Michigan	Complaint Counsel	October 15, 1979	1757-1806
Janzarik, Richard V.	716 North Wood Anderson, Indiana	Respondent	October 30, 1979	2525-2554
Kasle, Myron J.	Indiana University School of Dentistry	Intervenor	November 1, 1979	2712-2742

Kos, John	The Equitable Life Assurance Society of the United States	Intervenor	October 29, 1979	2338-2375
MacKillop, Donald K.	63 Fox Den Road Glastonbury, Conn.	Complaint Counsel	October 15, 1979	1835-1858
Miele, Frank, Dr.	16 High Gate Court St. Charles, Ill.	Complaint Counsel	October 11, 1979	1414-1536
Mishler, Ernest	933 Briar Patch Lane Greenwood, Indiana	Complaint Counsel	October 5, 1979	908-954
Nelsen, Robert	271 East Bury Hill Rd.	Complaint Counsel	October 16, 1979	1950-1975
Nolting, Charles	Indiana State Board of Dental Examiners	Intervenor	October 29, 1979	2197-2338
Oliver, Richard T.	Lafayette West Lafayette, Ind.	Respondent	October 31, 1979	2631-2656
Pierce, James G.	Anderson, Indiana	Respondent	October 31, 1979	2563-2619
Roberts, Fred	2910 Bodine Drive Wilmington, Delaware	Complaint Counsel	October 4-5, 1979	629-810
Rohn, Ralph Daniel	Alexandria, Indiana	Respondent	October 30, 1979	2381-2524
Schade, Gerhard Rudolph, Jr.	887 Goodale Hill Road Glastonbury, Conn.	Complaint Counsel	October 9, 1979	968-1171
Shafer, William	Indiana University School of Dentistry	Intervenor	November 1, 1979	2681-2708

Witness	Address	Sponsor	Dates/ Testimony	Page References
Siegel, Henry	67 Park Terrace East New York City	Complaint Counsel	October 15, 1979	1826-1835
Speziale, John E.	4457 Angie Way Lilburn, Georgia	Complaint Counsel	October 5, 1979	811-907
Trego, Sam	4321 Cardinal Drive Indianapolis, Ind.	Complaint Counsel	October 12, 1979	1656-1682
Winkworth, Roy	109 Chippewa Drive Alexandria, Va.	Complaint Counsel	October 11, 1979	1536-1604

The demeanor and apparent credibility of all witnesses for both sides was generally quite impressive, with the sole exception of one of Respondent's witnesses, Dr. James Pierce, an organizer of Respondent, who consistently professed inability to remember important facts he might be expected to recall. It might further be noted that, surprisingly, Respondent's first President, Dr. David McClure, who has shared with Dr. Daniel Rohn the top leadership of virtually every Indiana effort to keep X-rays out of insurers' hands during the past decade, was never called to testify.

Approximately 440 exhibits were offered (90% by Complaint Counsel) and very generally received in evidence. This being in the nature of a conspiracy case, many of Complaint Counsel's exhibits were offered in evidence as acts and/or declarations of Respondent and/or Intervenor as hearsay evidence and urged to be inadmissible unless and until a *prima facie* case of conspiracy be established. Such exhibits were typically admitted by the Judge only for non-hearsay use (i.e., to prove the fact that a statement was made and any reasonable implication therefrom) but *not* for hearsay use (i.e., to prove the truth of the statement) unless and until Complaint Counsel should establish a *prima facie* case of conspiracy which would make Respondent responsible for declarations by other members of the conspiracy made during and in furtherance of it.

In accordance with the usual practice in conspiracy cases, the Administrative Law Judge did not attempt to decide at the time of each evidentiary ruling whether or not a *prima facie* case of conspiracy had yet been made out but postponed that determination until after trial. When closing the record on 11/16/

79 the Judge directed Complaint Counsel to "set out clearly in a special section of their proposed findings and conclusions the chief evidence on which they rely to establish the existence of the conspiracy alleged in the Complaint." "Complaint Counsel's Brief Supporting Conclusions Of Law" contains a section entitled "Bases For Admission Of Third Party Dental Society Documents Against Respondent." (pp. 28-31 incl.)[5] Complaint Counsel rely principally on three kinds of evidence to make their *prima facie* case:

(1) The testimony of Connecticut General's National Accounts Director Chichester[6] and former Indianapolis Regional Manager Roberts[7] to their personal experiences in dealing with IDA and its leaders when trying to set up and administer the General Motors/UAW dental health plan and likewise the testimony of Aetna's Group Claims Director Downes[8] and Claims Program Director Schade[9] to their personal experiences in dealing with IDA and its leaders when trying to set up and administer the International Harvester/UAW dental health plan. Their stories establish clearly the IDA-organized concert of action with regard to submission of X-rays to insurers and the important roles therein played by the future leaders of IFD.

[5] The problem arose mostly, although not entirely, with reference to documents of IDA, which was named as a co-conspirator but not a Respondent.

[6] See transcript references cited in CPF 112-13, 115-16, 120-22, 175.

[7] See transcript references cited in CPF 87, 112-13, 115-19, 121, 125-27.

[8] See transcript references cited in CPF 94-99, 105, 108-110.

[9] See transcript references cited in CPF 107-110.

(2) Detail about the IFD phase of the conspiracy, such as pressure put on insurers not to request X-rays and to abide by "gentlemen's agreements" developed during the IDA phase of the conspiracy, is found in the testimony of Connecticut General's former Indianapolis Regional Manager Speziale,[10] who also told of his dealings in regard to submission of X-rays with such continuing IDA/IFD leaders as Drs. McClure and Rohn.[11] Evidence that IFD was dedicated to fighting submission of dental X-rays to insurers is found in the testimony of Brockaway Glass' Personnel Manager Christianson[12] and ITT-Hoffman's Personnel Manager Trego.[13]

(3) Hearsay found in Respondent's own minutes or other declarations (whose admissibility thus does not depend on prior establishment of a *prima facie* case of conspiracy) can be used to prove IDA's prior conduct opposing X-ray submission;[14] the founding of IFD as a purported "union" to evade the antitrust laws against boycotts;[15] the deferral of IDA action against submission of X-rays to give newly-founded IFD a chance to work out an arrangement with insurers;[16] exchanges of reports on IFD and IDA actions regarding the X-ray question;[17] IFD members'

[10] See transcript references cited in CPF 180-82.

[11] See transcript references cited in CPF 134-35.

[12] See transcript references cited in CPF 151, 176-179.

[13] See transcript references cited in CPF 151, 183-187.

[14] CX 505A; CX 575A-C; CX 584A-E.

[15] See transcript references cited in CPF 140, 193.

[16] See transcript references cited in CPF 145, 157; see also CX 194K and CX 492A.

[17] See transcript references cited in CPF 145.

conduct conforming to its "Work Rule" and refusal to submit X-rays; [18] and statements in newsletters of IFD's position on the "Work Rule" and the submission of X-rays.[19]

We agree with Complaint Counsel that the evidence cited makes out a rich *prima facie* case of conspiracy. Accordingly, we now rule that all hearsay evidence received conditionally (i.e., dependent on proof of a *prima facie* case of conspiracy) is hereby relieved of such condition and is now received in evidence unconditionally.

Many times during the trial of this matter Respondent and Intervenor objected to "double" or "multiple" hearsay, usually in documentary evidence. Rule 805 of the Federal Rules of Evidence provides:

> "*Hearsay within hearsay.* Hearsay included within hearsay is not excluded under the hearsay rule if each part of the combined statements conforms with an exception to the hearsay rule provided in these rules."

In each case when a multiple hearsay objection was raised the Administrative Law Judge assured counsel that he did not propose to rule on the admissibility of each of the many instances of multiple hearsay often found in lengthy proposed exhibits but that even if the overall document was admitted, no weight would be attached to any part violative of Rule 805. We now make it clear that we have not intentionally relied on any multiple hearsay in any exhibit, if such part violates Rule 805. Any finding based in part on multiple hearsay implies that the Judge

[18] See transcript references cited in CPF 147-164.

[19] See transcript references cited in CPF 150, 153, 162.

thought that particular multiple hearsay fell within an exception to the hearsay rule as contemplated by Rule 805.

It proved necessary to admit certain exhibits after the last hearing day (11/1/79) but before the closing of the record. For the record, these exhibits are as follows.

> *IX 500-500C:* a statement of one major insurer's policy regarding "Review of X-rays", offered by Intervenor and received *in camera* by written order on 11/2/79.
>
> *CX 852, CX 853, CX 854:* certified copies of certain papers filed by the Federal Trade Commission in the suit against it by the State of Indiana in the U.S. District Court for the Southern District of Indiana (Civ. No. IP 79-462-C), offered by Complaint Counsel to supplement other papers from the same file offered by Intervenor and received on 11/1/79 as IX 1000-1000 GGG. The supplementary papers were received by written order dated 11/14/79.
>
> [It should be noted that the progress of the State's injunction suit after Judge Holder's judgment of intervention on 8/17/79 is dealt with hereafter in connection with the State's contention that certain findings by the District Judge are now binding on the Administrative Law Judge here by operation of collateral estoppel.] [20]

On 11/16/79 the record of this case was closed, subject to reopening for good cause shown any time before submission of the Initial Decision. On 12/21/

[20] See Para. 187 to 209, below.

79 Complaint Counsel submitted "Proposed Findings And Conclusions Of Counsel Supporting The Complaint" and "Complaint Counsel's Brief Supporting Conclusion Of Law." On the same date Intervenor served "Findings Of Fact And Conclusions Of Law." Some days later, pursuant to agreement of the parties and approval by the Administrative Law Judge, Respondent served "Respondent's Submitted Findings Of Fact And Conclusions Of Law." On or about 1/10/80 all parties served responsive papers as follows:

> "Respondent's Response To Complaint Counsel's Findings Of Fact And Conclusions Of Law."
>
> State of Indiana's "Response To Complaint Counsel's Proposed Findings Of Fact And Conclusions of Law."
>
> "Complaint Counsel's Reply To Proposed Findings Of Fact And Conclusions Of Law Of Respondent Indiana Federation Of Dentists And Intervenor State Of Indiana."

On 2/8/80 the Administrative Law Judge sought and on 2/14/80 the Commission granted an extension of time until 3/14/80 for the filing of the Initial Decision. A further extension of time to 2/24/80 was sought on 2/13/80 and on 3/18/80 was granted by the Commission.

OVERVIEW

This case explores the economic impact of mushrooming dental health care insurance on the practice of dentistry. Traditionally a dentist has been relatively unfettered in his diagnosis of a patient's

needs.[21] The patient might or might not be able to afford what the dentist recommended but the recommendation itself was hardly ever questioned by anybody. The phenomenal growth of group dental health care insurance in recent years [22] has changed all that. Insurers, naturally anxious to contain dental health care costs, have not generally been prepared to pay for anything that a dentist recommends.[23] Their covenants to pay dental bills have commonly been limited to payment of a reasonable charge [24] for work reasonably required.[25] That imports an objective standard of necessity. As a result someone besides the dentist must now be involved in deciding (or at least confirming) a proper treatment plan on which the payment of insurance benefits can fairly be based.

The economic interest of dentists in not being "second-guessed" by their patients' insurers is too plain to need elaboration. The experience of dental health insurers—who, of course, have their own bias—has been that correcting the treatment plans submitted by dentists in Indiana almost always means slimming

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[21] CX 139 I.

[22] CX 804Z-18 (group dental expense health insurance benefit payments up from $140 million in 1970 to $951 million in 1976); By 1978 some 48 million Americans were receiving prepaid dental care through a contract with their employers or unions (CX 584A).

[23] TR 394-95.

[24] The language commonly used is "usual and customary" charge. (CX 47H). However, the reasonableness of the fee is *not* an issue in this case.

[25] The phase commonly used is "least expensive yet adequate treatment" (CX 47K). The implementation of this phrase goes to the heart of the case.

them down rather than beefing them up.[28] Experience shows that an alternate benefits clause is a significant cost-containing mechanism.[29]

This is not to say that any large number of dentists deliberately set out to defraud whomever is paying the bill.[30] But where a range of opinion is possible it is not surprising for dentists and bill-payers to have honest disagreements of opinion as to how much dental work is really required in a particular instance. That economic conflict constitutes the background of this case.

It is worthwhile noting that this essentially economic struggle has been embittered by something equally deep-seated. The record reveals many comments by dentists reflecting the professional man's inevitable indignation at being "second-guessed". Such revealing phrases as "degrading abuse",[30] "sub-

[28] An Aetna survey in its Ft. Wayne office found 20 alternative course reductions in 21 referrals. TR 1351-52. An Aetna witness claimed this was based on bad statistics but an official investigation by the Indiana Insurance Commissioner found that only 7 percent of all alternate treatments discussed by an insurer's dental consultant with the patient's dentist resulted in an "upgrade". CX 810H. We do not accept Complaint Counsel's claim in CCPF ¶54 that alternate benefits clauses yield higher benefits in up to 25 percent of all cases. Even Complaint Counsel concede that "it is more usual for dentists to overtreat than to undertreat" (citing TR 332) and that "when alternate benefits are invoked it usually means that benefits will be paid for a less expensive treatment than that proposed" (citing TR 619, 915, 1379-80, 1507).

[29] TR 272, 276-77, 397, 527-28, 979, 980-81, 986, 1152, 1430.

[30] A top Connecticut General dentist/executive could recall no instance of intentional or fraudulent misrepresentation which that insurer had reported to any agency in the State of Indiana. TR 562.

[30] CX 394G.

jugating his own professional judgment,"[30] "dictate to the doctor"[31] and "questioned as to my professional integrity"[32] give some indication of the strong emotional component involved in the struggle here. When Respondent's leaders complain about insurers' "interference with the dentist/patient relationship,"[33] they are referring not only to the possibility of losing money but to a loss of personal pride.

The wrath of the dentists of Indiana has most frequently been vented on two practices of insurers which, the dentists assert, justify them in refusing to turn over their patients' radiographs (commonly called "X-rays") to insurers who want to see what the X-rays show. The first reason usually given for such refusal is that insurers rely too heavily on the X-rays (i.e., to the exclusion of oral examinations and other diagnostic aids). A second alleged reason is that insurers reportedly use lay personnel to read X-rays (under conditions discussed later). It is reasonable and indeed should be mandatory, they claim, for dentists to refuse X-rays to people who will only abuse them. The dentists do not usually refer to another possible reason but they must be presumed to intend the natural and probable consequence of refusing the X-rays to insurers: to make it harder, for insurers to second-guess dentists.

Be that as it may, insurers serving Indiana have found it much harder to get dentists to give up their

[30] CX 47K.

[31] CX 47J.

[32] TR 2714.

[33] This is a frequent phrase in the record here. See e.g., CX 397A.

patients' X-rays there than elsewhere.[34] This Complaint was brought by the Federal Trade Commission to find out why. If dentists' refusals to turn over X-rays to insurers have been based simply on dentists' individual decisions, there is probably no antitrust offense. Contra, however, if these refusals reflect even in part the influence of a concerted refusal to deal—a group boycott—one of the most heinous offenses known to the antitrust law. *Klor's, Inc.* v. *Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959).

In summary, what is in issue here is not whether dentists or insurers are right about what treatment is needed, either generally or in particular cases, nor even whether it is fair for dentists to individually withhold from insurers the X-rays which are so important in deciding on a proper treatment plan. The issue here is, rather, whether the Indiana dentists have unlawfully organized a *collective* effort—a *group* boycott—to try and keep those X-rays out of insurers' hands.

III. FINDINGS OF FACT

A. *Respondent*

1. The sole Respondent, Indiana Federation of Dentists ("IFD"), is an unincorporated association of Indiana dentists formed on August 24, 1976.[35] Article II, Section 2 of its constitution and by-laws makes membership open to any licensed Indiana dentist who endorses IFD's purposes and those of the American Federation of Physicians and Dentists, with which it

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[34] TR 290-92, 1471, CX 563A. The American Dental Association, for example, has never opposed submission of X-rays to insurers (TR 306, 1003-04).

[35] CX 477C; CX 22A.

is affiliated and to which each IFD member must belong.[36]

2. The "objectives" of IFD, as set forth in Article I, Section 2 of its constitution and by-laws, are essentially to represent the economic interests of Indiana dentists as a labor organization".[37] In pertinent part Section 2 reads:

> *Section 2. Objectives*:
>
> "The Indiana Federation shall represent, protect, maintain, and advance, through activities accomplished by relevant techniques which may lawfully be engaged in by a labor organization, the interests of the dentists within its jurisdiction. The objectives of this Federation shall include, but not be limited to the following:
>
> a.) To represent dentists in all socio-economic matters, negotiations and grievances with employers, third, and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public;
>
> b.) To seek to insure adequate compensation and proper working conditions for dentists commensurate with their training and skill and the responsibility they bear for the life and health of their fellow human beings;

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[36] CX 13C. It further provides that an IFD member must not be affiliated with any other collective bargaining agent for dentists.

[37] CX 13A-B. Also quoted in Par. 105, below.

c.) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of the highest quality of dental care;

d.) To associate together all dentists for their mutual benefit and protection;

e.) To unite the efforts of dentists in obtaining and preserving the individual freedom of action necessary for the success of their professional endeavors;"

3. Although IFD is open to dentists throughout Indiana, its membership has been and is still largely concentrated in three localities of that state.[38] As of June 1979 there were 46 members around Anderson (Madison County)[39] 27 members around Lafayette (Tippecanoe County)[40] and 19 members around Ft. Wayne (Allen County).[41] Obviously these are fairly small numbers in comparison with the 3,100 licensed dentists in Indiana[42] or the almost-as-large membership of the Indiana State Dental Society.[43] What IFD's members lack in numbers, however, they make up in the strength of their convictions. Immediately after issuance of this Complaint each member was

[38] See RPF 2, IPF 116, 117.

[39] CX 811A (including 100 percent of all dental specialists in the area).

[40] CX 811B (including 67 percent of all dental specialists in the area).

[41] Statistics on specialists are not available for Ft. Wayne because this Chapter was not formed until 1978 (CX 566A-B).

[42] TR 2261.

[43] The IDA mailing list is said to miss only 12-15% of all Indiana dentists (CX 303E).

assessed a thousand dollars for litigation costs here (in addition to usual dues of two hundred dollars per year).[44]

4. Respondent has argued that the Commission has no jurisdiction over this unincorporated association because it is not organized to carry on business for its own profit.[45] However, the merest consideration of its objectives[46] makes it clear that IFD is not a charitable organization but is organized to carry on business in substantial part *for the profit of its members*. Accordingly, it falls within the definition of "corporation" as provided by Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44 (1976).

5. Numerous cases support this Commission's jurisdiction over purportedly non-profit organizations such as trade associations which, however, promote the economic interests of their members. *FTC* v. *Cement Institute*, 333 U.S. 683, 690 (1948); *Fashion Originators' Guild of America* v. *Federal Trade Commission*, 312 U.S. 457 (1941); *National Commission on Egg Nutrition*, 88 F.T.C. 89, 175-177 (1976), *aff'd.*, 570 F.2d 157 (7th Cir., 1977), *cert. den.*, 439 U.S. 821 (1978); *FTC* v. *National Commission on Egg Nutrition*, 517 F.2d 485, 487-88 (7th Cir. 1975), *cert. den.*, 426 U.S. 919 (1976); *Chamber of Commerce* v. *FTC*, 13 F.2d 673, 684 (8th Cir., 1926); *National Harness Mfgrs. Assn.* v. *FTC*, 268 F. 705,

[44] CX 12.

[45] Respondent's Answer to Complaint, Par. 17.

[46] See "objectives" set forth in Par. 2, above. Note also that IFD's application to the Internal Revenue Service for recognition of a federal income tax exemption was based on a claim that IFD is a labor organization rather than that it was a charitable association. CX 33A-B.

708-09 (6th Cir., 1920). Only one non-charitable purpose is necessary to give the Commission jurisdiction. *American Medical Association*, FTC Docket No. 9064, slip opinion of Commission issued 10/12/79, at page 5, fn.5.

6. Respondent IFD is not and never has been a labor union within the meaning of Section 6 and 20 of the Clayton Act (15 U.S.C. § 17 and 29 U.S.C. 52) which exempt genuine labor unions from the provisions of the federal antitrust laws. Similar associations of independent businessmen, including private practice physicians, organized for the purpose of dealing with powerful customers have been held not entitled to the benefit of the Clayton Act exemption. *Columbia River Packers Assn.* v. *Hinton*, 315 U.S. 143 (1942); *American Medical Assn.* v. *United States*, 317 U.S. 519 (1943). Evidences of efforts to dress IFD up as a labor union thus have no significance here except as they may tend to show guilty consciousness by IFD's founders that their activities would probably be unlawful under the Federal antitrust laws.[47]

7. Respondent IFD is obviously not engaged in the business of insurance—however defined—within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§ 1012, 1013(b), which makes the Federal antitrust laws inapplicable to the insurance business, except insofar as it is not regulated by State law. The insurers to whom Respondent's members have allegedly refused X-rays (thereby restraining their trade) are technically not engaged in the business of insurance either, because the Supreme Court has recently called risk-spreading and underwriting the essential ele-

[47] See Par. 94, below.

ments of "insurance", *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 211 (1979) whereas the "insurers" involved here typically operate on a cost-plus basis, passing the risk back to the group covered (e.g., all General Motors employees).[48] Even, however, if the kind of claims servicing functions performed by the "insurers" here be treated as "insurance" within the meaning of the McCarran-Ferguson Act, that Act expressly provides that nothing in it shall render the federal antitrust laws inapplicable to any "agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation." 15 U.S.C. § 1013(b). Thus the same proof of participation in an organized boycott which would tend to establish a boycott in violation of the antitrust laws would at the same time lift the prohibition of the McCarran-Ferguson Act against action by this Commission to end such a boycott.

B. *Interstate Commerce*

9. Under the Magnuson-Moss Warranty-FTC Improvement Act of 1975 [Title II, Sec. 201(a)] amending 15 U.S.C. 45, unfair methods of competition and unfair trade practices are within the jurisdiction of the Commission if they are in or affect interstate commerce. The practice of dentistry in Indiana is

[48] Under the Connecticut General/General Motors Plan the premium equals anticipated benefit payments during the coming year plus administration expense, share of overhead and profit (TR 507-08). Under the Aetna/International Harvester Plan, Harvester transfers funds to Aetna to take care of claims up to a certain limit beyond which Aetna assumes the risk. "Premium" is defined in this contract to mean the sum of Aetna's administrative costs plus anticipated claims (TR 1079-80).

obviously *not* in interstate commerce. However, much if not most of the business of dental health care insurance carried on in Indiana *is* in interstate commerce under the tests laid down in *United States* v. *Southeastern Underwriters Association*, 322 U.S. 533 (1944). The boycott alleged in the Complaint is by its very nature designed to affect such interstate commerce in insurance adversely by depriving insurers of the X-rays they need in order to determine the least costly adequate treatment for their insureds.

10. The necessary effect on commerce must be substantial and "it is not sufficient merely to rely on identification of a relevant local activity and to presume an interrelationship with some unspecified aspect of interstate commerce." *McLain* v. *Real Estate Board of New Orleans*, —— U.S. —— (1980) (Docket No. 78-1501, slip opinion of 1/8/80, page 9). However, federal jurisdiction for purposes of injunctive relief is not defeated by complaint counsel's "failure to quantify the adverse effect of respondent's conduct" or even by "inability to prove that concerted activity has resulted in (any) legally cognizable damages" *Ibid.*, page 10. The correct formula, as laid down by the Supreme Court in *McLain* is that:

> "To establish the jurisdictional element of a Sherman Act violation it would be sufficient for petitioners to demonstrate a substantial effect on interstate commerce generated by respondents' . . . activity. Petitioners need not make the more particularized showing of an effect on interstate commerce caused by the alleged conspiracy . . . or by those other aspects of respondent's activity that are alleged to be unlawful." *Ibid.*, page 9.

11. In this case, while Complaint Counsel do not attempt to quantify the extent to which Respondent IFD's boycott campaign has in fact affected commerce in interstate insurance, the record is replete with evidence of the magnitude of business done by interstate insurers in Indiana under dental health insurance contracts with predetermination and alternate benefits provisions. For this purpose we adopt and attach hereto as Figure 1, a tabulation prepared by Complaint Counsel [49] from evidence specified in detail in Complaint Counsel's Proposed Findings of Fact # 39 through # 44, now incorporated herein by reference. Figure 1 shows that during 1976 and 1977 more than a half-dozen well-known interstate insurers made benefit payments of almost $13 million into Indiana under dental plans with predetermination and alternate benefits features. An organized boycott attacking interstate business of this magnitude is a "substantial" restraint on such trade, whether or not the boycott ever succeeds.[50]

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[49] CCPF, page 20.

[50] "If establishing jurisdiction required a showing that the unlawful conduct itself had an effect on interstate commerce, jurisdiction would be defeated by a demonstration that the alleged restraint failed to have its intended anticompetitive effect. This is not the rule of our cases." *Ibid.*, pages 9-10. See also *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 785 (1975): "The fact that there was no showing that . . . buyers were discouraged by the challenged activities does not mean that interstate commerce was not affected. Otherwise the magnitude of the effect would control and our cases have shown that once an effect is shown, no specific magnitude need to be proved." [Citing *United States* v. *McKesson & Robins*, 351 U.S. 305, 310 (1956).]

Figure 1

45. Tabulation of 1976-77 Data Contained In CPFs 39-44

Interstate Payments Into Indiana Under Dental Plans With Predetermination And Alternate Benefits Features	Indiana		Anderson Area		Lafayette Area		Ft. Wayne Area	
	1976 *	1977 *	1976	1977	1976	1977	1976 *	1977 *
Aetna	$ 1,875,000	$ 2,250,000					$1,151,995	$1,453,751
CG	9,322,800	9,707,000	$2,141,100	$2,600,100				
Metropolitan	284,000	339,000						
Travelers	489,522 **	2,365,887			$3,694 **	$77,816		
Prudential	440,000	1,178,000						
Equitable	456,750	375,600						
Other Relevant Interstate Dental Benefit Payments								
Peter Paul Inc. (Frankfort, Ind.)					$3,870	$18,864		
Johns-Manville (Alexandria, Ind.)			$ 11,476	***				
Totals	$12,868,072	$16,215,487	$2,152,576	$2,600,100	$7,564	$96,680	$1,151,995	$1,453,751

* Policy and calendar years, whichever the company uses to compute data.

** Statistics were available for only July-December of 1976 (*see* CPFs 39, 43).

*** Data for 1977 unavailable. The amount for 1978 was $8,986 (*see* CPF 44).

C. *The IDA Boycott*

12. The Supreme Court recently defined a "boycott" this way:

> "The generic concept of boycott refers to a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold patronage or services from the target." *St Paul Fire & Marine Ins. Co.* v. *Barry*, 438 U.S. 531, 541 (1978).

Unlike some legal definitions, this one conforms closely to the common understanding of the same word.[51] Our immediate task is to determine whether the record here fairly establishes a boycott and, if so, what if any role Respondent has played in organizing it and/or keeping it going.

13. The allegation of the Complaint in (Pars. 9-10) is that Respondent Indiana Federation of Dentists, when formed in late August 1976, simply took over a going conspiracy organized by IDA to keep dental X-rays out of insurers hands. When dawning consciousness of illegality led IDA to give up the fight, IFD was organized as a "labor union" by the old leaders to continue the same boycott in a new guise, Paragraph 11 of the Complaint charges. A mass of evidence supports this allegation.

14. Indiana Dental Association (IDA) is a "constituent society" of the American Dental Association.[52] Its membership in 1974 encompassed about 85 to 88 percent[53] of the State's 3,100 licensed den-

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[51] "To combine against a landlord, tradesman, employer or other person, to withhold social or business intercourse from him and to deter others from holding such intercourse." Webster's New International Dictionary, *vide* "boycott".

[52] CX 798E; CX 799E.

[53] CX 303E.

tists.[54] Its members automatically belong to 14 affiliated "component" (i.e., local) dental societies,[55] which elect representatives to the state association's governing body, known as the House of Delegates.[56] IDA's top executives including a President, Secretary and Board of Trustees, are elected statewide annually.[57]

15. Sometime before 1970, in response to the appearance of industrial and other group dental insurance plans, IDA had set up a Council On Dental Care Programs (CDCP) composed of representatives from each of the 14 local societies.[58] It was its duty among other things, to "formulate Association policies, standards and principles for evaluating group-funded dental care programs (public and private) subject to approval of the House of Delegates".[59] The three areas (Anderson, Lafayette and Ft. Wayne) where anti-insurer sentiment was strongest and which would eventually give birth to the three chapters of IFD were always well-represented on CDCP. Future officials of IFD who sat on IDA's Council On Dental Care Programs during the 70's are shown in Figure 2. Attention should be called to the prominent roles played in the Council during much of the '70's—even after the formation of IFD—by Dr. Dan Rohn (Vice Chairman and then Chairman, 1974-1977) and Dr. David McClure (Consultant at Large, 1976-1979), the two principal figures in IFD.

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[54] TR 2261.

[55] CX 3B, CX 4B, CX 5B, CX 6B, CX 7C, CX 8B, CX 9B, CX 10B, CX 11B.

[56] CX 798G; CX 799G.

[57] CX 798L; CX 799I.

[58] CX 3D; CX 72C; CX 99D; CX 433.

[59] CX 798Q; CX 799M.

Figure 2

Future IFD Officials Who Served
On IDA Council On Dental Care Programs

			Evidentiary References	
Year	Name	Area	IFD Membership	CDC Positions
1970-71	Dr. Robert Gayle	Ft. Wayne	CX 21	CX 3D
	Dr. Richard Harrison	Anderson	CX 18A	CX 3D
1971-72	Dr. Robert Gayle	Ft. Wayne	CX 21	CX 4D
	Dr. Richard Oliver	Lafayette	CX 20B	CX 4D
	Dr. Paul Van Dorn	Anderson	CX 18B	CX 4D
1972-73	Dr. Robert Gayle	Ft. Wayne	CX 21	CX 6D
	Dr. Richard Oliver	Lafayette	CX 20B	CX 6E
	Dr. Paul Van Dorn	Anderson	CX 18B	CX 6D
1974-75	Dr. Robert Gayle	Ft. Wayne	CX 21	CX 7D
	Dr. Richard Oliver	Lafayette	CX 20B	CX 7E
	Dr. Dan Rohn	Anderson	CX 18B	CX 7D
	Dr. Paul Van Dorn	Anderson	CX 18B	CX 7D
1975-76	Dr. Richard Fontaine	Lafayette	CX 19A	CX 8E
	Dr. Karl Gossweiler	Anderson	CX 18A	CX 8D
	Dr. Dan Rohn	Anderson	CX 18B	CX 8D
	Dr. David Steele	Anderson	CX 18B	CX 8D
1976-77	Dr. Richard Fontaine	Lafayete	CX 19A, 20A	CX 9D
	Dr. David McClure	Anderson	CX 18A	CX 9D
	Dr. Dan Rohn	Anderson	CX 18B	CX 9D
	Dr. Charles Sabel	Lafayette	CX 19A, 20B	CX 9D
	Dr. David Steele	Anderson	CX 18B	CX 9D
1977-78	Dr. David McClure	Anderson	CX 18A	CX 10D
	Dr. Charles Sabel	Lafayette	CX 19A, 20B	CX 10D
	Dr. David Steele	Anderson	CX 18B	CX 10D
1978-79	Dr. David McClure	Anderson	CX 18A	CX 11D
	Dr. Charles Sabel	Lafayette	CX 19A, 20B	CX 11D
	Dr. David Steele	Anderson	CX 18B	CX 11D

16. These roles have been in *addition* to other significant positions in IDA held by these future IFD officials, all as shown in CX 2A-E. Dr. Rohn, for example, was President of the Indiana Dental Association for 1972-73 and Dr. McClure was Secretary of the Indiana Dental Association from 1970 until 1976 (the year that IFD was formed with McClure as President and Rohn as Vice President). Drs. Rohn, McClure and Oliver, along with Dr. James Frey of the Ft. Wayne area, another future IFD official, made up half of a special six-dentist "task force" on Dental Care Programs set up to supplement the work of CDCP during the critical 1976-77 period.[60] Dr. Rohn chaired *both* the Council and the task force.[61]

17. IDA's attitudes and policies toward dental health insurance plans have long been embodied in an official "Manual On Group Funded Dental Care Programs."[62] It first appeared in January 1968; a second edition was published in November 1969; and revisions were made thereafter in May 1972, May 1974 and May 1976.[63] The "Manual" is one of the most important pieces of evidence here because it lays out so clearly and completely the IDA policies on which the boycott was based. It begins with an introduction by CDCP:

> "The purpose of this manual is to *give Indiana Dentists and their assisting staff an appropriate*

[60] CX 106, CX 490B.

[61] CX 106.

[62] CX 47, CX 72, CX 99.

[63] CX 47A, CX 72A and CX 99B. This record contains no later editions or revisions.

> *and useful guide to follow when providing dental care to patients having a group funded dental care plan* (public or private). By making this information readily available to Indiana dentists, *the Association policies and standing rules regarding group funded programs will be more meaningful; followed more uniformly;* and result in better services to patients and dentists alike." (emphasis added)[64]

18. Part II of the "Manual" ("Policy and Information") covers "I.D.A. Policy Regarding Group Dental Care," reciting adoption by I.D.A.'s House of Delegates on 5/22/62 and amendments by the same authority dated 1965, 1966 and 1972.[65] [The last revision in this record (1976) also recites amendments adopted in 1970, 1973, 1974 and 1975.][66] It begins with a section on "I.D.A. Policy Regarding Group Dental Care," subtitled "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care" (more commonly called "the Principals of Acceptability").[67] These "principles" cover a number of matters such as IDA participation (but without contractual commitment) in the development of such plans; maintenance of a high standard of dental treatment and compliance with IDA's Code of Ethics; freedom of patients to choose their dentists and vice versa; eligibility of all licensed dentists to participate, etc.[68]

[64] CX 47C.

[65] CX 47E.

[66] CX 99F.

[67] CX 47E.

[68] CX 47E.

19. Of particular importance here is Principle Number 6, which reads as follows:

> "6. The areas of responsibility involved in the administration of the Plan must be recognized and properly evaluated.
>
> a. The administration of the professional phases of the plan should be entirely within the control of professional personnel. Professional standards and treatment should not be controlled by non-dental administrators.
>
> b. The method of authorization of dental health care under pre-payment plans should be limited to determining the eligibility of the patient and extent of liability of the plan and should prevent any interference with the dentist-patient relationship or with the judgment and decision of the dentist. The plan must not *require* the dentist to submit[69] radiographs (X-rays) to a third party. (emphasis in original)
>
> c. The submission of a total estimate is acceptable, *if requested by the patient.* (emphasis in original)[70]

20. Note well that while Principle #6 is clearly opposed to insurance contracts which compel production of a dentist's X-rays at the request of the insurer, this Principle does *not* take the next step: directing dentists to refuse to submit X-rays to third

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[69] Later revisions inserted here "either pre or post operative." See CX 99F.

[70] CX 47E.

parties on request. However, a subsequent part of the "Manual" contains a form letter to be sent by dentists on I.D.A. stationary "To All My Patients," which does, indeed, take the next step. Paragraph No. 5 reads:

> "Dental radiographs (X-rays) are a part of the dentist's legal health records. They are available for valid review by a qualified representative(s) of your insurance company in this office. *Radiographs (X-rays) will not be submitted to third parties for their use in determination of benefits* (e.g., least expensive adequate procedure or optional course of treatment) because a determination of an adequate treatment plan can only be made after a knowledge of the following:
>
> A. Complete patient evaluation
>
> B. Radiographs
>
> C. Additional diagnostic procedures as required." (emphasis added)[71]

21. Paragraph 5 of the form letter "To All My Patients" plainly directs Indiana dentists not to send X-rays to insurers for the only purpose insurers would want them: to determine insurance benefits. It can be argued—that the provision permitting "qualified" insurance personnel to come to the dentist's office to study X-rays prevents the passage in question from amounting to a total blockage of access to the X-rays.[72] However, there is unchallenged

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[71] CX 47G. See also CX 72F and CX 99 I (same wording in later revisions of Manual).

[72] The same invitation to check X-rays in the attending dentist's office appears in a "sample letter to (insurance) carrier if carrier requests X-rays. . . ." CX 47X; CX 72O; CX 99V.

testimony in this record to the effect that it is not economically feasible and in any event it would be a terrible waste of time to have insurers' professional dental consultants constantly travelling from office to office to talk to dentists (when available) and look at their X-rays.[73] As a practical matter, we find that Paragraph 5 of the Manual amounts to a plan by IDA for Indiana dentists to boycott insurers. Whether the boycott could be justified, as attempted in the suggested Paragraph 5, on a theory that working from X-rays alone without "complete patient evaluation" and "additional diagnostic procedures" is inadequate for proper determination of a treatment plan is, of course, a separate question, reserved for consideration hereafter.[74]

22. A subsequent section of the Manual is entitled "Uniform Method For Processing Group Funded Dental Care Plans," [75] and goes into great detail on how a dentist should deal with his patients (including giving them copies of the "To All My Patients" letter described above). Under "Points to Discuss with Patients" occurs this enlightening advice from IDA to its dentist members:

> "1. Pre-authorization or predetermination is required by some group-funded dental care programs.[76] The dentist will cooperate with

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[73] TR 341-42, 924-25, 978, 1221, 1232, 1383-84, 1457; CX 303E; CX 316.

[74] See Pars. 120-148 below (re reasonableness of the restraint).

[75] CX 47I *et seq.*; CX 72H *et seq.*; CX 99K *et seq.*

[76] The testimony here was that predetermination is usually required for work expected to cost over $100, although inflation has recently been driving that figure up to $125. (TR 393, 535-536, 980).

this procedure by providing the patient with a treatment plan on the Uniform Report Form if—

a. the plan does not interfere with the dentist's professional judgment (i.e., attempt to dictate to the doctor and his patient what and/or how the service should be performed).

b. It is *limited* to determining the extent of liability of the plan.

c. It does *not* require the submission of preoperative radiographs.

2. Some insurance plans provide for "alternate benefits". Usually, the wording for this in a plan is, ". . . *the least expensive yet adequate treatment.*" If this is the case, be sure the patient understands that the treatment plan the dentist has proposed may not be accepted by the insurance company. Instead, the company may pay for a *less expensive or optional* course of treatment which the third party determines to be adequate. In this event the dentist and patient have two options:

a. Continue with the original treatment plan with the patient understanding that he will be reimbursed for only part of the cost of treatment.

b. If the patient elects the alternate treatment as determined by the insurance company, the dentist should consider the fact that in proceeding with a treatment plan prescribed by a third party, he (the

Dentist) is put in the position of justifying, both morally and legally, the results of this plan, which is not of his own making. And moreover, in subjugating his own professional judgment to a third party, he is negating his claim to a professional status and, in fact, has become merely a mechanic carrying out a treatment plan designed by someone who has never seen his patient and whose qualifications are unknown. Thirdly, by accepting such third party diagnosis, the dentist will be setting a dangerous precedent which could have far reaching implications, affecting the professionalism of dentistry." [77] (emphasis in original)

23. The strong *feeling* evident in this passage provides revealing background for the *action* called for by the next part of the Manual. This instruction is found in an "Attending Dentist's Statement" to be given by a patient to an insurer as a claim form.[78] The front and rear are shown here as Figures 3A and 3B respectively:

[77] CX 47J-K.

[78] CX 47L-M; CX 72I-J; CX 99M-N.

ATTENDING DENTIST'S STATEMENT — Figure 3-A

CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE ☐ DENTIST'S STATEMENT OF ACTUAL SERVICES — CX ID-47-L

Spaced for Typewriter - Note: for Tabulator Appear on this Line

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING DRUGS, PROSTHESIS MATERIALS USED, ETC.)	DATE PERFORMED (MO., DA., YR.)	ADA NOMENCLATURE NUMBER	FEE	FOR CARRIER USE ONLY
		Initial Oral Examination	6 4 72	00110		
		Intra-Oral Complete Series	6 4 72	00210		
13	1	Amalgam-one surface-permanent:	6 4 72	02140		

SAMPLE

INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

ORTHODONTICS (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)
DATE FIRST APPLIANCE INSERTED
DATE LAST APPLIANCE REMOVED
TREATMENT PERIOD (months anticipated)
TOTAL FEE $

TOTAL FEE ACTUALLY CHARGED
PATIENT PAID
BALANCE
CARRIER PAID

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.
(Signed (Patient, or Parent if Minor)) DATE

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE ☐ HAVE BEEN ☐ PERFORMED
(Signed (Dentist)) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.
(Signed (Insured Person)) DATE

-34- Form Approved by the Council on Dental Care Programs of the A. D. A., June, 1971
* Form Approved by the Council on Dental Care Programs of the A. D. A., August, 1971

BEST AVAILABLE COPY

FIGURE 3-B

YOUR DENTIST wishes to cooperate with you as his patient in order that you may learn the extent of your dental care insurance coverage and how much will be paid to you.

In order to avoid any misunderstanding, we urge you to read the *following* information:

1. Our professional services are rendered on the basis that all costs of treatment will be paid by the patient.

2. In some plans, the dental insurance contract is written to provide for the least expensive, adequate procedure as determined by the insurance company. The carrier will request x-rays to make this determination. If your contract is written in these terms, please give special attention to the following:

A. The Indiana Dental Association does not agree with such a contract.

B. Trying to determine if a treatment plan is adequate based on x-rays alone is impossible without an in-office examination of the patient.

C. X-RAYS WILL NOT BE SUBMITTED TO A THIRD PARTY FOR THIS PURPOSE.

D. Your dental insurance contract is an agreement between you and/or your employer and their insurance carrier. Indiana dentists are not bound by any dental care insurance contract stipulation.

[Federal Trade Commission Stamp]

24. Figure 3-A is a critically important piece of evidence. It dispels any impression that IDA is merely expressing an academic disagreement or an academic belief. Paragraph 2-C of Figure 3-A is an action sentence. When it says, in standout type, that *X-rays will not be submitted to a third party for this purpose*," (emphasis added) ADA is now telling its dentists to tell their patients that this is the way it is going to be. As in Paragraph 5 of the "To All My Patients" form letter,[79] *IDA here again makes it clear that Indiana dentists are expected by ADA to join in a boycott of the insurers serving that state.*

25. Not only were these identical words still on the back of IDA's claim form in the latest record revision of IDA's "Manual" in 1976 (the year that IFD was founded),[80] but the rule had actually been tightened up in important respects.[81] Significantly, the 1976 revision of the "Manual" was systematically distributed to *all* members of the Indiana Dental Association by order of Dr. David McClure for IDA's Council on Dental Care Programs[82] during the same time that he was organizing and becoming the first President of the Indiana Federation of Dentists.

26. It is now well established that an organization of professionals whose members accept and follow anticompetitive organizational policy declarations may

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[79] See Pars. 20-21 above.

[80] CX 99N.

[81] In May 1976 IDA added to the form its opposition to the whole alternate treatment concept (CX 99G); affirmed that an insurer's inspector must be a duly Indiana licensed dentist (CX 99W); and insisted that an insurer must pay the treating dentist a "consultation fee" (CX 99W).

[82] TR 2500-01; CX 104.

be found to have conspired with its members to that end. *United States* v. *National Society of Professional Engineers*, 389 F. Supp. 1193, 1201, 1216 (D.D.C., 1974), *vacated*, 422 U.S. 1031 (1975), *affd. on remand*, 404 F. Supp. 457 (D.D.C., 1975), *affd. and modified*, 555 F.2d 978 (D.C. Cir., 1977), *affd.*, 435 U.S. 679 (1978); *United States* v. *Texas State Board of Public Accountancy*, 464 F. Supp. 400, 403 (W.D. Tex., 1978), *affd. per curiam as modified*, 592 F.2d 919 (5th Cir., 1979), *cert. den.*, 48 U.S.L.W. 3283 (10/29/79); *American Medical Assn.*, FTC Docket # 9064, slip opinion of 10/12/79 at p. 21; *appeal docketed*, Civ. No. 79-4214 (2d Cir., 12/3/79). Here there is abundant evidence that IDA's boycott policy was, in fact, accepted and followed by many if not most of its members. We now review that evidence.

D. *The Pledge Project (1973)*

27. Perhaps the most striking evidence of the backing which the membership of IDA has given such leaders as Drs. McClure and Rohn is found in a so-called "pledge project" which these two dentists co-chaired in early 1973.[83] The pledge card itself is reproduced here as Figure 4.[84]

[83] CX 124 and CX 125.

[84] CX 126C.

FIGURE 4

CX ID-126-C

Name

Address

Component

I.D.A. Member Yes —— No ——

The above mentioned dentist was contacted on ——— by Dr. ————————.

His reason for not signing the pledge card is as follows:

PLEDGE

As a member of the dental profession licensed to practice in the state of Indiana, I am obligated from a professional and legal point of view to provide my patients the best dental care I can deliver. This care is based on a mutual understanding between the patient and the dentist.

Certain group-funded dental plans can interfere with the principle of maintaining a high standard of dental treatment. Therefore, I will participate in all plans within the framework of the Principles of Acceptability approved by the *Indiana Dental Association.*

(Signature)

(Date)

[Federal Trade Commission Stamp]

27.1 In an invitation to certain dentists to attend a project orientation meeting and "leadership training session" the project was explained this way:

> "As you know, there is significant rapid growth of group-funded dental care programs in Indiana. *The I.D.A. has prepared to meet this challenge through the development and implementation of the 'Indiana Plan'. We know it will work because it has worked successfully for many ongoing programs in Indiana.* True, there is a major program that is giving us trouble (Aetna-International Harvester-U.A.W.)[85] and this must be resolved.
>
> .....
>
> With the advent of many more programs—particularly the pending U.A.W. Auto Contract[86] —— we must make sure the "Indiana Plan" continues to work and work well, or we stand the chance of being dictated to by some distant third party. With this in mind, the I.D.A. Board of Trustees has approved a statewide "Indiana Plan" pledge project program.
>
> .....
>
> What we are asking is that you be one of our key representatives to take the pledge project to the (local) component societies; give them the 'pitch'; and bring home the pledges. *Once this has been accomplished we can say, with proof,*

[85] Highlights of the Aetna-Harvester-U.A.W. struggle with I.D.A. are summarized in Par. 40 *et seq.*, below.

[86] Apparently refers to the Connecticut General—General Motors—U.A.W. contract which was to become effective the following year (1974). See Par. 53 *et seq.*, below.

> *to any third party that Indiana dentists actively support the "Indiana Plan".* (emphasis added)[87]

28. Attendees at the "pledge project" orientation meeting were each given a "training kit" containing various materials for canvassers to study in preparation for making their "pitch".[88] A list of "ideas for presentation" included a reaffirmation of IDA's position that 'there are many factors that guide a dentist in his determination of a treatment plan" and that "proper dental treatment is predicated on a diagnosis from many types of examination and *not radiographs alone*" (emphasis added).[89] It warned that "if dentists allow third-party [insurer] intervention, we will soon find ourselves technicians rendering a service sold, priced and controlled entirely by a third party."[90] The "pitch" of most importance here was a final appeal for collective action:

> "The road ahead *depends upon the unity* that will be generated among Indiana dentists. It is time to close our ranks and look to the future. *Unity =Negotiating Power.*"[91]

29. The same occasion brought forth numerous other references to the need for professional solidarity in dealing with the insurers:

Dr. Lloyd Phillips (IDA's Trustee in the American Dental Association)

> "We have assumed that Indiana's position was and is one of strength because the members of

[87] CX 125.

[88] CX 139A through CX 139-Z4.

[89] CX 139M.

[90] CX 139M.

[91] CX 139M.

the Indiana Dental Association believed in the 'Indiana Plan' and supported it with action. *We are here today to organize an evangelistic brigade to go out and preach the gospel*; to explain the principles; give the reasons why they should be supported; and then ask each member to indicate his support and his belief by signing a pledge." (emphasis added)[92]

Dr. David McClure (Secretary of IDA)

"Two weeks ago G.M. sent their top negotiator to Anderson to meet with Dr. Van Dorn and me. . . . They are very aware of us and would never have sent this type brass down if they weren't concerned. *It boils down to their respect for our unity and I do feel that we can influence our future.*" [93]

. . . . . .

"A few weeks ago we met with officials from Equitable Life Assurance Society. . . . Here again *they respect unity*" (emphasis added)[94]

Dr. Dan Rohn (President-Elect of IDA)

"In order to make a profit and be competitive, the (insurance) carrier must have some kind of cost control. The union doesn't want the traditional methods of cost control such as a table of allowances, a deductible plan, or any limitation on benefits. The (insurance) carrier then must control costs by controlling the dentist. A fee schedule is one way of doing this. Another is the

[92] CX 139C.

[93] CX 139G.

[94] CX 139H.

most recent 'gimmick'—a clause which states the least expensive adequate treatment *as determined by the carrier!* (emphasis in original)

What this really means is that the insurance company reserves the right to review the dentist's treatment plan, examine his X-rays, make a diagnosis of oral disease, and alter the treatment plan as they see fit to suit their economic considerations. We know this has been done by untrained, unqualified and unlicensed people.

We know this has happened in the past; we know this is happening now; and we know it will continue to happen in the future unless *we assert ourselves.* (emphasis in original)

Just how do we think we can interject ourselves in these negotiations and effect (sic) the way a contract will be written? By showing *unquestionable solidarity!* (emphasis in original) *By obtaining a pledge from every practicing dentist in the State of Indiana stating that he will not provide his professional services with any group funded plan whose procedures and requirements do not meet the standards of the Indiana Dental Association.* (emphasis added)

If we can get a majority of the practicing dentists in the state to give us this pledge, we can assert ourselves as a fourth interested party. (emphasis added)

We can advise local labor and management groups of how much solid support we have for our principles. (emphasis added) They have already told us they will listen. . . . *They know that they cannot receive any dental benefits un-*

less we are willing to service their agreement. (emphasis added) To obtain these pledges *we must have your cooperation.* (emphasis added) We want to face every dentist in the state; explain our position as we have done here today; and ask him to sign a pledge to show support for these principles." [95]

30. The IDA party line during these years—with one eye on the Justice Department and a possible charge of restraint of trade—seems to have been that IDA merely determines whether an insurer's plan "does not appear to be in the best interests of the doctor-patient relationship" and informs "the general membership" of "the general picture," leaving it to the dentists to "react as individuals".[96] However, the foregoing passages clearly evidence a plan to mobilize Indiana's dentists into an "evangelistic brigade": brandishing a *collective*, not an *individual* refusal to deal with the insurers serving the State.[97]

31. IDA's well-organized "pledge project" to enlist added support for the work of IDA's Council On Dental Care Programs was, in fact, a "tremendous success", with several of the association's fourteen local component societies actually achieveing 100 percent support for the IDA Principles of Acceptability.[98] Dr. Robert Gayle of Ft. Wayne, for example, reported to Co-Chairman Rohn that he had addressed 26 of the 48 members in the Richmond area, all of whom signed a pledge card and agreed to assist in getting the other

[95] CX 139J-K.

[96] CX 74A.

[97] CX 138.

[98] CX 138.

men that were absent to sign a pledge card.[99] He further reported:

> "I felt as though the subject was well received and from the comments made, the concept of unity would be worked for in the area." (emphasis added) [100]

Overall, CDCP's Chairman reported, more than 85 percent of IDA's membership responded that they would support the Principles of Acceptability.[101]

32. In IDA's house organ Co-Chairman Rohn, by then President-Elect of IDA, wrote:

> "In the past year, as we have met with insurance carriers and different management representatives, they would often reply that we didn't speak for the IDA membership at large. So the pledge project was concerned with the idea that we must know if we are on the right track when advocating policy that the dentists of Indiana through their House of Delegates have approved.
> .....
>
> What does this overwhelming success mean? It means that we have *unity* (emphasis added) and your leadership can go to insurance carriers, unions and management with these pledge cards in our pocket. We can inform them that the dentists of Indiana do support their Association's Principles of Acceptability. Any contract that is

[99] CX 133.

[100] CX 133.

[101] CX 74A.

written without taking this into consideration will have problems in Indiana." [102]

It would be hard to imagine a more clear-cut acceptance of IDA's proposed concert of action. The only remaining question is whether the IDA boycott *proposed* by its leaders and *accepted* by "a vast majority" [103] of its members was, in fact, *followed.*

The Post Card Survey (1975)

33. Two years after the Pledge Project, IDA's Board of Trustees reaffirmed support for the IDA Principles of Acceptability [104] and had the IDA central office conduct an official survey by mail of the membership's thoughts and actions on X-rays and dental insurance programs.[105] No attempt was made to identify respondents.[106] The questions asked by the survey were as follows:

"1. Are you in private practice in Indiana? (If 'No' you need not answer the other questions. Please return the card.)

2. Are you receiving payments from third parties (insurance companies) for X-rays?

3. Are you presently sending X-rays to third parties?

4. If the answers to questions 2 and 3 are 'No', would you send X-rays if requested?" [107]

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[102] CX 142A.

[103] CX 64B.

[104] CX 144.

[105] CX 145A.

[106] CX 144.

[107] CX 145A.

34. Of 2,000 surveys mailed to IDA's members, 1,342 or 67 percent were returned [108] and of the 1,342 returns 1,268 or 95 percent were from private dentists.[109] The results of the survey by component societies, as tabulated by IDA's central office for IDA's top leadership at the time, are shown in Figure 5.[110] They reveal that statewide, although 811 members were getting requests for X-rays from insurers only 133 members were sending X-rays to the insurers.[111] Of another 407 members who reported neither getting requests nor sending in X-rays, only 29 said they would do so if requested, while 378 said they would refuse.[112]

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[108] CX 145A.

[109] CX 145A.

[110] CX 145C.

[111] CX 145C.

[112] CX 145C.

Figure 5

Results of post card survey on X-rays by Component Societies Jan. 28, 1975

Component Soc.	1. Are you in private practice in Indiana? yes	1. Are you in private practice in Indiana? no	2. Are you receiving requests from third parties for x-rays? yes	2. Are you receiving requests from third parties for x-rays? no	3. Are you presently sending x-rays to third parties? yes	3. Are you presently sending x-rays to third parties? no	4. If the answers to questions 2 & 3 are NO, would you send x-rays if requested? yes	4. If the answers to questions 2 & 3 are NO, would you send x-rays if requested? no	TOTAL RESPONSES
Ben Hur	15	0	4	11	0	15	0	10	15
East Central	83	4	34	51	1	82	0	49	87
Eastern Ind.	26	2	18	8	1	25	1	7	28
First District	105	3	61	44	4	99	3	39	108
Greene District	16	1	12	5	1	15	0	5	17
Indianapolis Dist.	318	34	217	93	55	253	8	74	352
Isaac Knapp	105	4	83	22	4	101	1	20	109
North Central	128	6	63	62	4	122	5	54	134
Northwest	169	11	134	30	31	133	7	20	180
South Central	84	1	53	32	14	69	0	28	85
Southeastern	38	2	23	13	4	32	0	12	40
Wabash Valley	62	3	42	18	7	53	0	18	65
West Central	63	1	36	27	4	59	2	24	64
Western Indiana	56	2	31	22	3	47	2	18	58
Grand Total	1268	74	811	438	133	1105	29	378	1342

35. The percentage of dissidents in the three areas which would later spawn IFD (Anderson, Lafayette and Ft. Wayne) was a little less (6%) than in the state as a whole (16%) but it seems plain that, even viewed statewide, most Indiana dentists were or at least claimed to be refusing insurers' requests for X-rays as of early 1975. The inference is inescapable and we accordingly find that most Indiana dentists were not only agreeing in theory but following in practice the plan to boycott insurers sponsored by IDA during most of the 1970's.

36. The existence of an IDA conspiracy to deprive dental health care insurers of X-rays needed to determine insurance benefits seems well-established by the evidence reviewed above and it would seem unnecessary to elaborate further on it. However, Complaint Counsel have asked for additional findings on the subject with which we agree and which we now cursorily adopt. These are as follows.

37. Complaint Counsel point out (in CPF #66) that IDA leaders believed they needed unity to implement the Indiana Plan and the Principles of Acceptability and members were repeatedly so instructed. The record citations [113] support this. They point out (in CPF #67) that IDA officials repeatedly urged IDA members to refrain from submitting X-rays to third-party payers (or even to dentists' patients) and to refrain from cooperating with any plan requiring predetermination of benefits or alternate benefits features, frequently advising IDA members as to which dental plans were (or were not) in compliance with IDA's Principles of Acceptability.

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[113] CX 39B; CX 62; CX 71B-C; CX 73; CX 104; CX 135; CX 139C-E; CX 459J.

This proposed finding, too, is well-supported by the cited evidence.[114]

38. CPF #68 recites how IDA contacted numerous insurers, managements and labor organizations, informing them of IDA's Indiana Plan and that its members did not submit X-rays to insurers. This proposed finding, too, is supported by the record[115] as are the proposed findings that IDA's CDCP and officers attempted to assert as much input as possible into the dental plan of General Motors and the U.A.W. prior to that plan's 1974 implementation date[116] and that IDA's CDCP and Board of Trustees urged all members to get their patients to write the Indiana Insurance Commissioner when dental insurance companies paid benefits at a lower level when X-rays were not submitted.[117]

F. *Two Boycott Targets*

39. The actual operation of IDA's group boycott is perhaps best understood by tracing its struggles with two leading dental health care insurers, Aetna Life and Casualty Insurance Co. and Connecticut General Life Insurance, both of Hartford, Connecti-

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[114] CX 38A; CX 39A-B; CX 43B, D; CX 55; CX 62; CX 64B; CX 71A; CX 75A; CX 82A; CX 99G, I, K, L, N; CX 108A, B; CX 144; CX 47-Z6.

[115] CX 63A-B; CX 64B; CX 74A-B; CX 84C-D; CX 101A-B; CX 327S-T.

[116] CX 71A.

[117] CX 82A, C, D. The Insurance Department apparently received several such patient complaints but announced in May 1975 that an insurer's reduction of benefits when X-rays were not submitted constituted neither a violation of Indiana insurance law nor an "unfair claims practice" (CX 841).

cut, and both substantial, well-known, nation-wide enterprises. Other, smaller insurers had generally gone along with the Indiana dentists' demands.[118] Not so these two. The result in each case has been was a running battle, with ups and downs, that has lasted several years. Each account is illuminating.

1. *Aetna-International Harvester-United Auto Workers*

40. Pursuant to a collective bargaining agreement between International Harvester and United Automobile Workers, on July 1, 1971, Harvester's employees in 23 states, including Indiana, came under the coverage of a dental health insurance plan.[119] Indiana locations affected were Indianapolis, Ft. Wayne and New Albany (on the Ohio River).[120] The Aetna-Harvester contract contained both predetermination and alternate benefits features[121] and Aetna's practice was to implement the latter by requesting and using X-rays to review benefit claims as necessary.[122]

41. Trouble started immediately.[123] A few days before the plan took effect Aetna officials met with representatives of IDA and its Ft. Wayne area component (known as the Isaac Knapp District Dental Society)[124] to discuss how the plan would work[125] but

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[118] CX 39B.

[119] TR 987, 1221. And see CX 222C.

[120] TR 987, 1221; CX 222C.

[121] TR 987.

[122] TR 975-76, 987, 1219, 1238.

[123] TR 987-89, 1242-43.

[124] CX 4B.

[125] TR 1222; CX 197A.

were told by the dentists that the submission of X-rays would violate IDA's Principles of Acceptability.[126] Promptly thereafter (6/30/71) a letter to all Indiana dentists from IDA's Council on Dental Care Programs notified them that the Aetna-Harvester plan did not comply with the Association's Principles and urged all dentists treating Harvester patients not to turn over dental X-rays either to Aetna or the patient.[127] Aetna countered with a letter on 7/1/71 to Indianapolis and Ft. Wayne dentists explaining its position and pointing out that its sole purpose in requesting X-rays, when it did, was to determine benefits payable.[128] The response was not encouraging.

42. While some Indianapolis dentists did submit X-rays to Aetna,[129] strong resistance was encouraged in the Ft. Wayne area, where only a small percentage of dentists would submit X-rays to Aetna.[130] In August the Chairman of IDA's CDCP complimented the Isaac Knapp dentists on their "all-out support" of IDA's Principles[131] and the November issue of IDA's Journal reported that 90 percent to 95 percent of all Ft. Wayne dentists were "*cooperating with*

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[126] TR 989-991, 1225; CX 197A. Again, at another meeting with Aetna later in July, IDA representatives repeated that the plan was unacceptable and that X-rays would not be submitted. TR 1228-30.

[127] TR 1234-35; CX 38A.

[128] TR 1238; CX 274A-C.

[129] CX 80A; CX 222C.

[130] CX 196B; CX 213H; CX 222C; CX 227B; TR 1243-44.

[131] CX 39B.

Isaac Knapp and IDA and not sending X-rays in." (emphasis added)[132]

43. It should be noted, however, that this near-unanimity of action by the Ft. Wayne dentists cannot be attributed entirely to agreement on the desirability of IDA's boycott policy; some was undoubtedly the result of powerful peer pressure. An Aetna dentist/executive who made the rounds of Ft. Wayne dentists on a special mission late in 1972 or early in 1973[133] testified that when these dentists were requested in the privacy of their offices to submit X-rays to Aetna there were two general reactions: "dentists who said despite the fact that you seem fair, I will not send X-rays to you; and others who said I would like to but I don't dare to."[134] Asked to quantify this division of opinion, the witness estimated that "the reaction of those we visited was about fifty-fifty."[135] This estimate tends to confirm that to a substantial extent the conformity achieved by IDA was an unwilling product of peer pressure.

44. In the face of this widespread refusal by Ft. Wayne dentists to submit X-rays to Aetna, how did Aetna deal with such a difficult situation? In gen-

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[132] CX 196B. The Journal added: "We hope that all of Indiana dentists will follow suit with the IDA principles (principles?) when the situation arises in their area."

[133] TR 1274.

[134] TR 1275.

[135] TR 1276. Note that a much larger percentage of the Ft. Wayne dentists (50%) were telling Aetna that they did not really sympathize with the boycott than would be suggested by the 1975 data for the Isaac Knapp Society as reported in Figure 5 above (only 4 out of 101 sending in X-rays and only one other dentist saying he would have sent in X-rays if requested).

eral it proceeded to pay benefits for those dental procedures which were covered by the plan in any event, such as radiographs, prophylaxes, certain fillings, root canal procedures, etc.[136] However, without X-ray proof of loss and generally without any other information on which to base a judgment Aetna declined to pay for various other procedures such as fixed bridge work and certain crowns.[137] During the first year under the Aetna-Harvester contract there accumulated something like 600 questionable claims which Aetna would not pay either in whole or in part, for lack of X-ray evidence.[138] It was the consensus of Harvester, U.A.W. and Aetna that many of these 600 claims were probably meritorious and that they had to be taken care of in some way.

45. Since the summer of 1971 Aetna had tried in vain to hire licensed Indiana dentists to review X-rays in its Indianapolis and Ft. Wayne claims offices.[139] To this end it had supplied IDA with a statement of criteria for dental consultants and asked for nominations but never received any.[140] By mid-1972, however, it had found licensed dental consultants: a Dr. Stone for its Indianapolis office and a Dr. Bohnke for its Ft. Wayne office.[141] Dr. Stone seems to have had relatively little trouble, so far as this record shows, but Dr. Bohnke had a great deal.

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[136] TR 1243.

[137] TR 1243.

[138] TR 1267.

[139] TR 1264-65.

[140] TR 1264-65.

[141] TR 1264-65.

46. Bohnke, who lived about 20 miles from Ft. Wayne but was a member of the Isaac Knapp Dental Society, took on both responsibility for counseling Aetna's current claims work and—to satisfy Harvester and U.A.W.—a special assignment to re-review all of the 600 questionable claims which we have seen had accumulated during the first year of Aetna's contract because requested X-rays had not been submitted for the claims.[142] To accomplish the latter "one-time" job it was arranged for him to go to the office of each dentist concerned and work with the relevant X-rays and any other diagnostic aids in the dentist's files.[143] This *modus operandi*, of course, came quite close to meeting IDA's unrealistic terms for insurer access to X-rays: "qualified" personnel to come to the treating dentist's office.[144] However, Dr. Bohnke also appealed to his fellow dentists to submit their X-rays to Aetna on request in the future[145] and this predictably evoked bitter enmity among his brethren of the Isaac Knapp Society.

47. On 1/29/73 a Dr. Scheele reported to Dr. James Frey, the Isaac Knapp Society's President-Elect, Chairman of its "Censor" Committee, and a future official of IFD, that he (Scheele) had been approached by Aetna "with a deal to take all their X-rays" [presumably whenever attending dentists declined to turn over their X-rays to Aetna] and elaborated that "I even received a personal call from their head consultant" (Dr. Bohnke) whom Scheele

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[142] TR 1267.

[143] TR 1267, 1274.

[144] TR See Par. 21, above.

[145] TR 1268.

immediately informed of his own decision not to cooperate with Aetna.[146]

48. On 2/19/73 Dr. Frey reported this approach by Dr. Bohnke to the Isaac Knapp Society's Board of Directors, which promptly voted, on motion duly made and seconded, to recommend that:

> "Harold Bohnke, D.D.S., be censored for encouraging another dentist, Ronald Scheele, D.D.S., through cohesion (sic) to participate in dental treatment of patients which directly violate the Indiana Dental Association's Principles of Acceptability. Specifically a deal to take all of Aetna Casualty (sic) Company's dental X-rays, for the purpose of submitting these X-rays to their company." [147]

49. Thereafter, (apparently to be entirely sure of their legal position before attacking Dr. Bohnke), Isaac Knapp's members on 3/14/73 unanimously amended its "Local Code of Ethics" to read as follows:

> "It shall be considered unethical and not prudent for the legally practicing dentists in the Isaac

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[146] CX 218.

[147] CX 215. See also CX 216A recomending the censorship of Dr. Bohnke and adding: "This applies to any other member of Isaac Knapp." For similar efforts by Isaac Knapp members to discipline a Ft. Wayne dentist named Dr. Don Lloyd who had allegedly "openly submitted" X-rays to third parties, see CX 214A-C and CX 216B. The complainants wrote Dr. Frey: "We . . . will not sit idly by and let one oral surgeon control the majority of oral surgery performed on Harvester employees and their families, especially when he is doing this by direct violation of the Principles of Acceptability of our Society." CX 214B.

> Knapp District Dental Society to release radiographs from the patient's file records, no matter what the intent or purpose may dictate, unless these said radiographs are to be sent to another dentist or physician for referral reasons." [148]

50. On 3/27/73 Dr. Frey wrote Dr. Bohnke a warning letter (Figures 6A and B), reciting the new amendment to the "Local Code of Ethics" and charging that "on numerous occasions" Dr. Bohnke had contacted various members of the Society with "a deal to take all of Aetna Casualty Company's dental X-rays for the purpose of submitting these X-rays to their company." [149] Dr. Frey then sternly admonished his colleague:

> "I would strongly recommend that you do not continue this policy. You would place yourself in a position of being censored for encouraging another Isaac Knapp dentist through coehsion (sic) to participate in dental treatment of patients which directly violates the Code of Ethics of the Isaac Knapp District Dental Society and the Indiana Dental Association's Principles of Acceptability." [150]

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[148] CX 220A.

[149] CX 220A.

[150] CX 220A.

FIGURE 6A

INDIANA DENTAL ASSOCIATION
A Constituent of the American Dental Association

1013 Hume Mansur Building • 317-638-1341
Indianapolis, Indiana 46204

CXID-220-A

President-elect

March 27, 1983

Harold W. Bohnke, D.D.S.
224 North 12th Street
Box 461
Decatur, Indiana 46733

Harold:

This letter is to inform you of the recent amendment to the Local Code of Ethics of the Isaac Knapp District Dental Society passed unanimously at the March 14, 1973 business meeting. The amendment reads as follows:

> "It shall be considered unethical and not prudent for the legally practicing dentists in the Isaac Knapp District Dental Society to release radiographs from the patients' file records no matter what the intent or purpose may dictate, unless these said radiographs are to be sent to another dentist or physician for referral reasons."

It has been called to my attention that on numerous occasions you have contacted several Isaac Knapp dentists with:

> "a deal to take all of Aetna Casualty Company's dental x-rays for the purpose of submitting these x-rays to their company."

I would strongly recommend that you do not continue this policy. You would place yourself in a position of being censored for encouraging another Isaac Knapp dentist through cohesion to participate in dental treatment of patients which directly violates the Code of Ethics of the Isaac Knapp District Dental Society and the Indiana Dental Association's Principles of Acceptability.

[Federal Trade Commission Stamp]

FIGURE 6B

INDIANA DENTAL ASSOCIATION
A Constituent of the American Dental Association

1013 Hume Mansur Building • 317-638-1341
Indianapolis, Indiana 46204

CXID-220-B

President-elect

Harold W. Bohnke, D.D.S.
224 North 12th Street
Box 461
Decatur, Indiana 46733

Page 2—continued

I hope that the contents of this letter are completely clear to you as a member of the Isaac Knapp District Dental Society. If you have any questions regarding this matter, please feel free to contact me.

Cordially yours,

Dr. James D. Frey, D.D.S.
IKDDS Chairman of Censor
and Public Relations

JDF/jc

cc: Dr. James Dumas
Dr. David Bleeke
Dr. Don Lahrman
Dr. Ralph Merkel

[Federal Trade Commission Stamp]

51. This record does not indicate that Dr. Bohnke was, in fact, ever "censored" but Dr. Frey's stern warning (along, no doubt, with other peer pressure) plainly had its effect. During the rest of the year 1973, under pressure from Harvester and U.A.W.,[151] Aetna proceeded apace with the program referred to in the Scheele-Frey letter, even buying a portable X-ray machine for the Ft. Wayne office.[152] This program called for Aetna's local office to itself begin taking the necessary X-rays (with a copy to the attending dentist) whenever an attending dentist indicated that he would not submit his X-rays to Aetna.[153] (This was to be determined in advance; if the attending dentist had already taken X-rays Aetna did not duplicate the X-rays but did an in-mouth examination).[154]

52. This program did not, in fact, get under way until January 1974, largely because Aetna could not until then get a licensed Indiana dentist to act as a dental consultant in its Ft. Wayne office.[155] Dr. Bohnke understandably declined to take on the new job, giving as his reasons that he feared criticism of his objectivity and an ethics charge by his peers.[156] What Aetna ended up doing was to bring Dr. Stone up from Indianapolis one day a week to read X-rays

[151] TR 1277.

[152] TR 1276.

[153] TR 1277.

[154] TR 1276, 1278.

[155] TR 1276.

[156] TR 1279.

and make in-mouth examinations.[157] As an estimated extra cost of $47,000 (4,700 examinations @ $10 per estimation)[158] Aetna managed to keep its Harvester business at Ft. Wayne alive until November 1978, when this Commission's order in *Indiana Dental Association*, Docket No. C-2957, considerably relieved the pressure of IDA's X-ray boycott.[159]

2. *Connecticut General-General Motors United Auto Workers*

53. A collective bargaining agreement between the automotive giant, General Motors Corporation, and United Automobile Workers, negotiated in 1973, provided for a dental health care insurance program for GM's employees and their families, to become effective 10/1/74.[160] Among GM's many plants throughout the United States are several in Indiana, including two in Anderson which employ a large part of that city's population.[161] The embattled IDA dentists exerted themselves to see that the administration of the GM/UAW dental plan was not given to Aetna[162] and, in fact, Aetna was by-passed by GM in favor of Connecticut General Life Insurance Co.[163]

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[157] TR 1276. In 1975 Dr. Stone was succeeded by a Dr. Levy, who ran the operation until 1978, when it was apparently no longer needed.

[158] TR 1278.

[159] TR 1321; and see RPF #12 (citing TR 919, 922, 1282).

[160] TR 391, 1760-62; CX 483A-B.

[161] TR 874-75; CX 254A; CX 477C; CX 486B. Dr. McClure estimated that 95 percent of his patients were connected with GM. CX 327F; CX 390B.

[162] TR 224.

[163] TR 391.

54. Anxious to avoid a repetition of the misfortunes which had befallen Aetna,[164] Connecticut General started as early as August 1973[165] to meet with IDA to work out a mutually satisfactory way of administering the GM/UAW plan, particularly the troublesome pretermination and alternate benefit provisions thereof.[166] After a January 1974 meeting to go over the plan's provisions together a CG representative reported:

> "The main emphasis of our meeting was the reiteration of the fact that Connecticut General was willing to work with the Indiana State Dental Association and that we would, in fact, treat them differently than they had been treated by other insurance carriers (Aetna). Our whole thrust, therefore, was to instill in them the feeling that we were an organization that could understand their problems and would respond to them so long as they met us half way. I think we again accomplished this objective."[167]

55. CG's euphoria was justified only to a slight extent. CG wanted IDA's cooperation in persuading competent dentists to serve as dental consultants[168] and the IDA representatives readily agreed to help

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[164] CX 312A.

[165] CX 327D.

[166] TR 392, 633, 1767, 1958.

[167] CX 303A. This and other citations to the GC minutes of the meeting of 1/9/74 (CX 303A-F) should be read in conjunction with the trial testimony of an attendant for CG (Chichester) concerning the same meeting, at TR 401-11.

[168] TR 402.

select dental consultants.[169] CG at this time also contemplated referring contested alternate benefit questions to a local Peer Review Committee[170] and the IDA people agreed to provide information on their 14 district Peer Review capabilities.[171]

56. On the critical issue of submitting X-rays, however, there was definitely no meeting of the minds. The four IDA representatives, headed by Secretary McClure (future IFD President) reiterated the Association's position that if CG wanted to send a professional dental consultant into IDAers' offices they would be willing to let him examine the X-rays but the CG representatives protested that this would be a "tremendous waste" of a professional's time and "no real compromise at all."[172] CG's spokesmen thought the provision of X-rays when needed as part of the proof of a claim was "legitimate" and "efficient" and, moreover, that there had to be consistent treatment for GM workers all over the country.[173] However, Dr. McClure remained "adamant", indicating that dentists in the Anderson/Muncie area were still unwilling to supply insurers with X-rays for pretreatment review[174] and could not be persuaded to release X-rays "even possibly to the Peer Review Committee, never mind a CG consultant."[175]

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[169] CX 303C.

[170] CX 303D.

[171] CX 303D.

[172] CX 303E.

[173] TR 407.

[174] CX 303E.

[175] CX 303F; TR 408.

57. Despite CG efforts to maintain an aura of good feeling between IDA and CG,[176] Dr. McClure wrote CG's Director of National Accounts (Chernyka) on 2/21/74 that he felt they had "gotten off on the wrong footing" and that the dentists were now so "disillusioned" that it would be "virtually impossible to find the type of dental consultant you seek to help in the administration of the plan."[177] Without Chernyka's knowledge McClure sent a copy of this letter to UAW and GM who were much upset and told CG to get this straightened out immediately.[178] In a phone call to McClure Chernyka greatly regretted that UAW and GM had been told of the problem; said he was telling McClure things he could not say in an open meeting and that the IDA people should not get upset over quality control (*i.e.*, the X-ray issue), as "it was just a lot of verbiage and it would be just what we as an association would want to make it."[179]

58. Another meeting was set up for March 19th,[180] at which the IDA representatives, headed by McClure, agreed to "put together a program of how we (IDA) believe you (CG) would obtain the most cooperation from Indiana dentists."[181] Such a program was outlined in a 4/19/74 letter on IDA stationery from McClure to Chernyka.[182] The first "good advice" by

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[176] CX 327E.

[177] CX 327F and G.

[178] CX 327H.

[179] CX 327 I-J.

[180] CX 327H.

[181] CX 327L.

[182] CX 327L.

Dr. McClure was to remove all mention of radiographs from CG's claim form. He explained:

> "We are certain you observed on March 19 that Indiana dentists have a *definite and unified position* (emphasis added) with regard to use of radiographs. Indiana dentists are opposed to the improper use of radiographs by insurance carriers using them for diagnostic purposes as a base for determining alternate courses of treatment which are less costly." [183]

59. On the affirmative side, IDA was agreeable to supplying CG with a list of recommended consultants but wanted an opportunity to "review annually and submit recommendations regarding the consultants."[184] It proposed to replace the insurer's contingent of non-professional people screening incoming claims by programming norms such as utilization patterns, frequencies of occurrence, treatment patterns, etc. into a computer; the computer would then "red flag" particular claims for reference to a consultant to in turn consult with the treating dentists and, if still unresolved, then to be referred to IDA's peer review committee for adjudication—at a fee.[185] [IDA also suggested submission of any other problem cases for peer review.] [186]

60. On 5/1/80 the McClure letter of 4/19/80 to Chernyka was answered by another CG official, Caffrey, whose attitude and approach seems to have been rather different from Chernyka's. Caffrey thought the

[183] CX 327L.

[184] CX 327L.

[185] CX 327L.

[186] CX 327M.

proposed consultant program had "a lot of merit," gave "full support" to peer review and agreed to "look into" the possibility of computerized screening.[187] As for his policy on X-rays, however, it was mailed fist in the silk glove. "We may have a problem on the question of radiographs," he wrote, in the understatement of the year.[188]

61. CG had "agreed" with GM and the UAW that radiographs would be reviewed as part of the basis for determining benefits.[189] Caffrey was prepared to assure IDA that this would be done "in a proper manner," which turned out to mean only "by licensed dentists." [190] [It is not clear whether even this assurance covered "screening" as distinguished from full-scale "reviewing" of X-rays]. Nowhere did Caffrey explicitly raise an issue as to *whether* X-rays should be viewed in the attending office or the insurer's claims office; he quietly *assumed* the latter: "If the attending dentist would like, he can mail the claim form and radiographs to the attention of the dental consultant." [191]

62. Not surprisingly, Dr. McClure was furious. To the IDA members who had been meeting with Connecticut General and John Sparks of UAW he promptly sent copies of the Caffrey letter and his own reaction thereto:

> "Caffrey's letter is contrary to everything that was promised or agreed to (at the 3/19/74

[187] CX 327N-O.

[188] CX 327N.

[189] CX 327N.

[190] CX 327N.

[191] CX 327N.

meeting). . . . I kept telling Chernyka that we couldn't see how they could promise us that there would be no X-rays when it was in black and white in the contract. He kept telling us that all the Union and Management wanted was results. So now we can see that they are really in a bind and maybe they can't deliver on their promises."[192]

He further reported that on receiving the Caffrey letter he had immediately called CG headquarters in Hartford, conveyed IDA's feelings about being "misled", informed them that "there would be no way the Indiana dentists would agree to send X-rays to a consultant" and laid down the law: "I suggested that if CG wanted any cooperation from us they would send a telegraph saying the letter was incorrect."[193] He further told Chernyka that IDA would not supply CG with a list of consultants if Chernyka expected them to diagnose from X-rays alone.[194]

63. Although there were divided counsels within CG,[195] Chernyka caved in and agreed to send the wire Dr. McClure wanted. At first he worded it so that the X-ray question would be left up to the consultant and the treating dentist but McClure stonewalled and Chernyka thereupon agreed to say that any problems would be resolved before the Peer Review Committee.[196] The wire that was actually sent read:

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[192] CX 327P.

[193] CX 327P.

[194] CX 327P.

[195] CX 308A-B; CX 309A-B.

[196] CX 327P.

"Disregard ref. to radiographs and [in?] Caffrey's 5/1/74 letter. Question of radiographs to be resolved by Peer Review Committee if dental consultant and attending dentist cannot resolve whatever questions there may be."[197]

64. Dr. McClure was apparently satisfied with CG's promise that there would be no compulsory submission of X-rays. He recognized, however, that the apple cart might still be upset:

"They will promise us anything to get (keep?) the Union (U.A.W.) from taking the contract away from them. I believe Sparks would take it away if he knew they had promised the no-X-ray bit. We must really zero in on our members and *educate them for the big confrontation we will have in the future. The only way we will whip it is by standing firm.*" (emphasis added)[198]

65. On 5/23/74 Caffrey formalized CG's request for assistance in selecting dental consultants, specifically asking for two practicing general practitioners to work 6-12 hours a week in CG's Indianapolis claims office.[199] One of their duties was said to be to "advise on benefit determination on claims where there is a question on . . . treatment"[200] but nothing was said about whether they would be reviewing X-rays at CG's office or at the offices of attending dentists.[201]

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[197] CX 327R.

[198] CX 327Q.

[199] CX 313A.

[200] CX 313A.

[201] CG's Indianapolis Manager testified at trial that at this time Indianapolis consultants were expected to work in that

66. On 6/25/74 the Executive Director of IDA, writing for "the IDA Officers and Trustees representing the areas of Indiana having major GM plants" submitted to CGF's Caffrey three nominees from the Anderson/Muncie area, including Dr. James Pierce (of whom more later), one from the Kokomo area and one from the Indianapolis area.[202] Nothing in IDA's letter of nomination bore one way or the other on the submission of X-rays to CG.

67. All but one of the five nominees were hired.[203] On 8/7/74 CG asked Dr. McClure for more Indianapolis nominations[204] and on 8/16/74, McClure, writing on IDA stationery, nominated two more consultants, of whom one (Dr. Beavers of Indianapolis) was hired by CG.[205]

68. By late August IDA's Dr. McClure was hearing disturbing reports from CG's Indianapolis office manager that he was planning on using consultants to screen X-rays, that visits to dentists' offices were "prohibitive" in cost and that people high up in CG were already saying it was a "stupid idea" even to try to run the program without the X-rays.[206] Wor-

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office ("physically come into the office," TR 654). If they could not work out any benefit problems from the diagnostic aids sent in with the claim form and by talking by phone with the claimant's dentist, the matter would be forwarded to the local dental consultant (e.g., Pierce in Anderson) "for him to get involved in and to try to resolve" (TR 654).

[202] CX 314A-B.

[203] TR 651.

[204] CX 311.

[205] CX 378.

[206] CX 316.

ried IDA leaders agreed among themselves to use the leverage of their consultant arrangements to try and avoid submitting X-rays:

> "[W]e will have to withdraw our support of the consultants if they (CG) try to use them to read radiographs in the claims office. I (Dr. McClure) have contacted the consultants in my area and alerted them to what is going to happen." [207]

69. The message went to CG's Indianapolis regional manager who testified "[t]hat if we persisted and proceeded along our normal lines and requested X-rays, that they (IDA) would in fact place pressure upon the dentists that were serving as consultants to resign." [208] When the manager discussed this threat with his consultants they explained:

> "[t]hat they were members of the Indiana Dental Association and although they were reluctant and would not want to resign, that they felt an obligation and because of the pressure that would be placed on them to in fact resign." [209]

For whatever reason, the anticipated reversal of X-ray policy by CG did not then materialize.

70. Meanwhile, during the summer and early Fall of 1974, with the GM plan set to start on 10/1/74, another source of difficulty between CG and IDA emerged. It concerned CG's GM claim form. As early as April Dr. McClure had advised CG to remove all mention of radiographs from its standard claim

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[207] CX 316.

[208] TR 669.

[209] TR 671.

form.[210] The problem was that, contrary to IDA's advice, the form worked up by CG for use in GM plants throughout the country had a request for X-rays on the rear.[211] A CG Vice President on 5/13/74 explained that:

> "We have desperately tried to avoid having to have separate claim forms and instructions for people receiving treatment in the State of Indiana. We have tried very hard . . . to insist on uniform administration throughout the country." [212]

71. By September CG had apparently made a tentative decision to insert an IDA-approved clause in Indiana claim forms that would read: "The above section in regard to X-rays does not apply to IDA members." [213] Yet an internal CG memorandum of 9/11/74 reveals CG's continuing dilemma.[214] It was believed on one hand that to proceed with use of the standard claim form without some kind of Indiana exception (and to insist on uniform X-ray submission in Indiana) would probably entail dire consequences such as resignation of the consultants, no Peer Review mechanism, the end of communication with organized dentistry, instructions to all IDA members not to cooperate with CG and perhaps even a full fledged advertising campaign to discredit CG, etc.[215]

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[210] CX 327L.

[211] CX 316.

[212] CX 308A.

[213] CX 312B and CX 327B.

[214] CX 312A-B.

[215] CX 312A.

On the other hand it was also recognized that the Union (i.e., UAW) position would be decisive and the memorandum closed with a "hope" that CG could get a reaction from U.A.W. in order to properly evaluate the advisability of "reviewing our position in Indiana." [216]

72. A few days later Chernyka called Dr. McClure with a story that somehow word had "leaked out" about insertion of the Indiana exception in the GM claim form and that he had to go to Detroit to explain.[217] Gingerly he asked what the reaction would be in Indiana if CG had to "back down" on this promise.[218] Dr. McClure replied immediately that the IDA membership would feel that they had been "lied to" and that it "certainly wouldn't help Connecticut General's image in Indiana." [219]

73. Two days later Chernyka was in Indianapolis, direct from his visit to Detroit, with word that General Motors would not countenance an Indiana exception to the X-ray clause on the back of the GM claim form.[220] Still trying to ride both horses at once, however, Chernyka assured Dr. McClure that, whatever the claim form said, CG would *not* demand that the dentists send in X-rays. McClure, for his part, decided to "let" CG keep its consultants but to recommend that IDA members use their own model claim form.[221]

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[216] CX 312B.

[217] CX 327V.

[218] CX 327V.

[219] CX 327V.

[220] CX 327W.

[221] CX 327W.

74. On the strength of these mutual understandings (thereafter known as "the gentlemen's agreement") Dr. McClure assured IDA's membership that "Connecticut General has given us a verbal agreement on no X-rays and if they (CG) do request them our (IDA) Central Office should be notified immediately." [222] This precarious arrangement went into effect on 10/1/74.

75. During the first year and a half of experience with the CG-GM dental health plan the situation with regard to X-rays was quite complex. GM and UAW continued to insist that CG must have the right to obtain X-rays from dentists on request but CG had made a "gentlemen's agreement" with IDA not to exercise this right but, in fact, many Indiana dentists began sending in X-rays, anyway. From the Fall of 1974 to the Spring of 1976 the X-ray submission rates gradually increased in those parts of the State where CG had much business, except for the three areas that would shortly spawn IFD.[223]

76. CG's Indianapolis office eventually found itself getting about 50 percent of the X-rays it needed,[224] —except for those coming from the Anderson area, where only a "very low percentage"—about 2 to 4 out of 40 dentists—would ever submit X-rays when requested by CG.[225] By the Spring of 1976 CG was getting about 70 percent of needed radiographs from parts of Indiana where it had plants other than Madison County as compared with less than 1 percent

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[222] CX 327W.

[223] TR 630, 682-83, 688-89, 732-33.

[224] TR 630, 682-83, 688-89, 732-33.

[225] TR 689.

from Madison County.[226] Moreover, the handful of cooperative dentists in the Anderson area made their submissions only rarely and covertly, for fear of the reaction of the IDAers.[227] Indeed, some Anderson area dentists told CG's Indianapolis manager frankly that "there was really fear that pressure would be placed upon them by dentists in the community" if they submitted X-rays.[228]

77. That CG really wanted the X-rays cannot be doubted. At various times during the first year and a half of the GM plan CG did raise the subject of requesting X-rays but on such occasions the IDA people would always suggest retaliation, as by withdrawal of IDA approval for CG's consultants.[229] In each case CG apparently backed away from such a prospect.

78. As a matter of fact, IDA seems to have held CG in such a vice that CG could not even discipline its consultants without raising a storm. Dr. James Pierce, CG's Anderson consultant, was reluctantly allowed to operate out of his own office in Anderson instead of CG's Indianapolis claims office,[230] even though this was a cumbersome, time-consuming, expensive, unsupervisable arrangement [231] which precluded valuable discussions with CG's Indianapolis claims personnel.[232] This was allowed because, in the absence of X-ray submissions, the only alternative

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[226] TR 812-14.

[227] TR 812-13.

[228] TR 684.

[229] TR 671.

[230] TR 432-33, 816.

[231] TR 690-91, 816-17.

[232] TR 433.

offered by IDA was to send a consultant to each attending dentist's office at a professional hourly rate.[233]

79. Dr. Pierce was a member of the Madison County Dental Society [234] and was unconditionally opposed to submitting X-rays to insurers.[235] On the stand he conceded that in five years as a dental consultant for CG he had "practically never" requested X-rays from treating dentists and had gone to a treating dentist's office to review X-rays on only one or two occasions.[236] CG could be pardoned for feeling it was getting something less than its money's worth from Dr. Pierce.[237]

80. Yet when CG stopped referring claims to Dr. Pierce and tried to process them through its Indianapolis office, using in-house consultants,[238] the Anderson area dentists were up in arms [239] and the Madison County Dental Society, sparked by Dr. McClure,[240] in March 1976 adopted a resolution that CG had not kept its "gentlemen's agreement" to use Pierce as a local consultant for that area.[241] Again CG bowed to

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[233] TR 434.

[234] TR 2609.

[235] TR 2598-2600; CX 160B.

[236] TR 2565-72.

[237] A CG Vice President testified that CG could not have successfully conducted its dental insurance business in other states, using the same arrangements that it had with Dr. Pierce. (TR 435-37)

[238] TR 692-93.

[239] CX 327A-C; CX 319.

[240] CX 269: CX 270.

[241] CX 270.

this organized opposition; as of trial Dr. Pierce was still handling CG claims in Anderson.[242]

> [CPF # 121 notes that Pierce had told CG's local manager frankly about experiencing "peer pressure" regarding the X-ray issue (TR 817-18) but then denied this on the stand (TR 2574). The Administrative Law Judge finds that the testimony of Dr. Pierce, who could remember hardly anything about anything, is entitled to little if any weight for any purpose.]

G. *The Formation of IFD*

81. The earliest reference in this record to the possibility of organizing a union of Indiana dentists is a letter from an Anderson IDA member, Dr. Paul Van Dorn (later an IFD organizer), to the Chairman of IDA's Council on Dental Care Plans, dated 6/28/72.[243] In response to the Chairman's request Dr. Van Dorn reviewed his thoughts on how "federation or unionization" should be accomplished. He foresaw "nothing but trouble from the public if we involve the state association [IDA] directly in the dealing (sic) of this type" and suggested a separate entity (preferably a corporation) in which each IDA member would be given a "free subscription to the corporation" in the initial phase, "provided each member would sign a document similar to the document we had the people of Madison County sign, saying they would support the Indiana Plan and will stick together in adversity." (emphasis added)[244] He con-

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[242] TR 2565-67.

[243] CX 436A-C.

[244] CX 436A.

cluded his discussion with a plea for speed: "I think time is running out. The sooner we can get this accomplished the more likely we will not have trouble in the future. . . . If we have a strong union and our opponent understands this it will not be necessary for them to test our strength." [245]

82. Two months later, at an IDA Executive Committee meeting, attended, *inter alias*, by the Anderson area's Drs. Rohn and McClure,[246] reference was made to a pending proposal by a Dr. Robillard to form a labor union.[247] However, the group agreed that "the timing for such doesn't seem right" and a consensus called for a subcommittee of CDCP to "*develop the 'blueprint' for such an organization and have it ready when the time was right.*" (emphasis added)[248] Shortly thereafter (9/14/72) a "Robillard contact committee" was appointed, to be chaired by Dr. Van Dorn, who was also to begin investigating the possibility of forming a "guild".[249] The CDCP Chairman commented:

> "Certain areas of Indiana which will feel the full thrust of overpowering third parties [e.g., General Motors] feel that they should be prepared when the action is not in their best interest." [250]

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[245] CX 436B.

[246] CX 51A.

[247] CX 51C. It seems likely that the Robillard proposal had prompted the request for the Van Dorn letter of 6/28/72 just described.

[248] CX 51C.

[249] CX 439A.

[250] CX 439A.

83. Writing on 9/27/72 for help from a Florida dentist experienced in such matters, Dr. Van Dorn recited his assignment to contact all people interested in "*unionizing or guilding dentists for more cohension [cohesion?] in bargaining with third parties*" [251] (emphasis added) and asked particularly for a mechanism of organization, membership requirements and "legal considerations".[252] The same emphasis on more effective bargaining with insurers through collective action may be noted in minutes of a 12/13/72 Isaac Knapp (Ft. Wayne) Dental Society meeting: [253]

> "Dr. Robert Gayle [of Ft. Wayne, later an IFD official] announced that he is on an active, working committee on the state level that is looking into the feasibility of forming a dental union *that could deal effectively in collective bargaining with 3rd parties.*" (emphasis added).[254]

84. On 3/15/73 Dr. Van Dorn reported to CDCP on the progress of the unionization study.[255] Despite expressions of scepticism by others present as to the feasibility of unionization (e.g., Can dentists use the ultimate weapon: the strike?), Dr. Van Dorn urged the importance of continuing to study the mechanics of forming a union "now" so that it could be implemented promptly "if needed." [256] CDCP thereupon voted for an "informational Fall Workshop to study

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[251] CX 439A.

[252] CX 440.

[253] CX 451B-C.

[254] CX 451C.

[255] CX 459F. See also CX 459N.

[256] CX 459F.

the effects of unionization with regard to the dental profession." [257]

85. At the Fall Workshop (9/13/73) Dr. Richard Oliver of Lafayette, a member of CDCP and another future IFD organizer,[258] shared the podium with an American Dental Association Assistant Executive Director for Legal Affairs for a one hour program on "The Unionization Movement for Self-Employed Health Professionals." [259] Whether prepared for this program or for some other occasion, the record contains a statement made by Dr. Oliver about this time (sometime in 1972 or 1973)[260] entitled "Why Should A Dental Union Be A Separate Corporation And Not Part Of The Dental Association?" [261]

86. Dr. Oliver's ultimate conclusion was that while IDA could give a union its blessing and help it with initial financing and organization, nevertheless the union should be designed to operate as a separate corporate body.[262] In reaching a subordinate conclusion that professional societies make poor unions he stressed, *inter alia*, the diversity of interests which subjects members to many pressures when confronted by "third party interference" and would, he thought, be "a *definite handicap in the cohesion necessary for a union to function properly.*" [263]

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[257] CX 459F.

[258] CX 2B.

[259] CX 464B.

[260] CX 1Z-37; TR 2150-52.

[261] CX 455A-B.

[262] CX 455B.

[263] CX 455A.

87. This record does not show what, if anything, came of the Van Dorn Committee's work. During the next two years (1974-75) there was not much activity on the unionization front but the subject was not forgotten. On 9/18/74, during preparations for the GM contract to go into effect, Dr. McClure reassuring a GC Vice President that IDA dentists would not likely refuse to fill out pre-treatment forms for patients:

> "I told them that I didn't think this would happen because *as an association we were cognizant of the antitrust line we have to walk.* Although I did explain to them that *certain very influential dentists had a contingency plan to immediately form a union to implement such a boycott if the screws get too tight.*" (emphasis added) [264]

88. This is the earliest evidence in this record tying the reason for unionization to the antitrust problems inherent in a boycott by the State professional association. From contemporaneous evidence it appears that IDA was becoming sensitive to antitrust problems at this time because of its own experience.[265] Answering an out-of-state inquiry about the overall purpose of IDA's Principles of Acceptability the Chairman of IDA's CDCP wrote carefully:

> "With recent involvement with the Sherman Antitrust Act, organizations such as the IDA must be very careful in determining what is unacceptable and the manner in which our members are informed of this. There is the potential that we

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[264] CX 327W.

[265] CX 74A.

could be charged by the Justice Dept. as being in restraint of trade. As it is now we determine which [dental health insurance] plan does not appear to be in the best interests of the dentist-patient relationship and the general membership is informed of the general picture. They have to react as individuals." [266]

89. During April 1975 IDA's Assistant Executive Director was writing to the American Federation of Physicians and Dentists (a medical "union") to obtain an update on AFPD's activities, certain written materials used at a collective bargaining seminar at Cornell University and "any suggested reading resources concerning the subject of professional unions." [267] Clearly the thought of unionizing IDA was still alive, if not robustly so, in the Spring of 1975.

90. Two months later, on 6/16/75, the U.S. Supreme Court handed down its epoch-making decision in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), which held, *inter alia*, that Congress did not intend any sweeping "learned profession" exclusion from the Sherman Act; tightened up the tests for a *Parker* v. *Brown* (state action) defense; and further liberalized the interstate commerce requirement in such cases. The shocking impact of *Goldfarb* on the thinking of IDA's leaders comes across clearly in an unofficial review of events prepared 3 years later by

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[266] CX 74A. The IDA idea of what does not constitute a trade conspiracy is further illumined later in the same document: "We can't, as an organization, mandate anything binding on our members—we can only point out deficiencies in a situation." CX 74D.

[267] CX 467.

IDA unionization advocate Dr. Oliver of Lafayette for Respondent IFD: [268]

> "This [Goldfarb] decision by the Supreme Court, while not its main intent, lowered past barriers to antitrust scrutiny of the professions by the Federal Trade Commission.
>
> . . . . . .
>
> Before the ink was dry on 'Goldfarb' the F.T.C. began an intensive, nonpublic examination of the health care area, increasingly turning its attention to activities of the professional organizations of the providers of care." [269]

91. Early in 1976 the Madison County dentists resurrected consideration of unionization for dentists.[270] A committee to study the possibility worked under Dr. McClure for several months, meeting twice in Anderson.[271] On 5/24/76 Dr. Rohn, Chairman of IDA's CDCP, put an item entitled "Report of Madison County Investigation into a Dental Union" on the agenda for the next quarterly meeting of the Council (tentatively scheduled for 7/29/76 but actually held on 8/14/76). The minutes of the Council meeting show that after all other business was taken care of (and reported in some detail) the meeting was "adjourned to discuss the Union movement in the Anderson area," regarding which, however, the minutes are totally silent.[272] The minutes do state:

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[268] CX 583.

[269] CX 584D.

[270] CX 22A.

[271] CX 468.

[272] CX 108H.

> "Several (Council Members) pointed out that for months, years we (IDA) have been discussing the radiograph problem and members have been calling for action. It is time some action was taken." [273]

Ten days later the Indiana Federation of Dentists was born.[274]

92. On 8/24/76, 47 dentists from the Anderson area met there; heard Dr. Rohn expound on the pros and cons of unionism; listened to a study committee's report and proposal (delivered by Dr. McClure) for Madison County dentists to form a "union" to be affiliated with the American Federation of Physicians and Dentists; and voted 40 to 7 in favor of Dr. Pierce's motion to form such a union.[275] A second chapter was thereafter (3/30/77) formed in Lafayette [276] and a third somewhat later (4/9/78) in Ft. Wayne.[277]

93. The Constitutions and By-laws of the State Federation and each of its three local chapters are of record here,[278] as are 2/1/79 membership lists for each chapter: Anderson (46 members; about 39 "current"),[279] Lafayette (27 members; about 23 "current"),[280] and Ft. Wayne (19 members; "current" members not differentiated.)[281] On 1/15/77 the American Federation of Physicians and Dentists granted IDF a charter which recited the national federation's credo that:

> "only in and through a *united effort* can we be assured of receiving full and just compensation and due appreciation for our services, do hereby *band together* and establish this national union." [282] (emphasis added)

94. The sequence of events just reviewed suggests that *it was primarily consciousness of the antitrust risk inherent in IDA's organized boycott of Indiana's dental health care insurers—much magnified by the Supreme Court's 1975 ruling in Goldfarb —which led to the 1976 Madison County study of unionization and the eventual implementation thereof by the organization of IFD on 8/24/80.* There is an abundance of evidence to confirm this inference.

95. IFD's first press release, on 8/25/76, quoted President McClure (in part):

> "Noting that unions are exempt from antitrust laws, he says that unionizing will enable dentists to be heard in negotiating with insurance companies on the quality of care and conditions of treatment. Long active in . . . the Indiana Dental Association, Dr. McClure stated that *such organizations are subject to antitrust laws and therefore without the bargaining power of a union.*" (emphasis added) [283]

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[273] CX 108C.

[274] CX 22A-B.

[275] CX 22A-B.

[276] CX 534.

[277] CX 566B.

[278] CX 13A-Z2; CX 14A-Z; CX 15A-W; CX 16A-Y.

[279] CX 18A-B.

[280] CX 19A-B; see also CX 20A-C for past membership (similar).

[281] CX 21.

[282] CX 17.

[283] CX 477A-C.

96. On 8/27/76 IFD's and IDA's joint public relations counsel [284] wrote the Editor of "Dental Economics" in behalf of her client:

> ". . . [*U*]*nions are not governed by antitrust laws* . . . . The union leaders, I think, view the union as a *complement to the Indiana Dental Association*, with each having its separate function although *the general purpose of both is the same.*" (emphasis added) [285]

97. Dr. David Yater, an Anderson area dentist and member of IDA's CDCP who had become IFD's first Secretary,[286] on 9/8/76 explained to the Chairman of CDCP why a union was thought "the most viable alternative":

> "Having attended the last two House of Delegates sessions and Council on Dental Care Programs meetings, *I have been aware that there is a prevailing sense of apprehension in respect to antitrust liability.* The association [IDA] has been *consistently warned by legal council (sic) to be very careful* in its actions and the wording of all official responses to third parties regarding our policies and positions. With the *very real spectre of antitrust violation* hanging over their head the Council is having increasing difficulty formulating a positive action in behalf of the

[284] A Ms. Barbara Rafferty of the Indianapolis public relations firm of Caldwell & Van Riper was the official "IDA Public Relations Counsel" (CX 8L; TR 769) and also serviced IFD when it was formed (CX 33G, CX 35A, CX 476A-C, CX 477A-C).

[285] CX 476B.

[286] CX 2C.

> membership, in view of the recent FTC suit and investigation, and the proposed and anticipated actions of the Justice Department in these areas. *One of the major advantages to unionization is the unquestioned immunity to* [*from?*] *antitrust liability.*" (emphasis added) [287]

98. In a "status report" to a Ft. Wayne dentist on 10/26/76, Dr. McClure described the labor union front quite colorfully:

> "*We have always been very unified in the Anderson area but now we feel much more secure not having the antitrust albatros around our neck.*" (emphasis added) [288]

99. This is not to say that there was no other precipitating factor in the organization of IFD. Indeed, it appears that during this period there was a serious concern in the minds of IDA leaders, when CG installed a new manager in its Indianapolis claims office, as to whether CG was about to "welch" on its "gentlemen's agreement" not to request X-rays. See particularly a 6/16/76 letter from Dr. McClure to a CG Vice President reporting these rumors); "I cannot believe you would shake my hand and look me straight in the face and tell me that Connecticut General would work without X-rays in Indiana if you didn't mean it. . . . This was a firm commitment. . . . Have you changed your policy with regard to radiographs in Indiana?" [289]

101. McClure simultaneously took his old papers to John Ruckelshaus, Legal Counsel to Madison

[287] CX 434A.

[288] CX 489B.

[289] CX 323A-B.

County Dental Society,[290] to see what could be done about enforcing the "gentlemen's agreement".[291] [He eventually learned that there was not much that could be done].[292] At IDA's CDCP's summer session (8/14/76) it was reported that CG had changed its position with regard to requesting radiographs while still using IDA-approved dental consultants but it was decided to "leave the situation as it is" for the present.[293] This confrontation between IDA and CG was still going on when IFD was organized[294] a month later and almost certainly contributed to the feeling that it was time for a union.

102. Moreover, a union would no doubt be a good vehicle for IFD's purposes, even if there were no antitrust risks to consider. CDCP member and IFD Secretary Yater, for example, wrote CDCP's Chairman that IDA was "not designed nor intended to represent us in socio-economic or political areas" and

> "[w]e feel that to ask the Indiana Dental Association to continue to expand the scope of involvement into areas it was never intended to enter will eventually force a reconciliation (resolution?) of the issues in a Court of Law with the strong possibility of our receiving an adverse ruling. It is our opinion that *a more suitable vehicle is needed* to present us in these areas and that a union is the most advantageous choice to

[290] CX 323B.

[291] CX 327A and C.

[292] CX 108C.

[293] CX 108E.

[294] CX 328A-B.

> satisfy the needs previously mentioned." (emphasis added)[295]

Dr. McClure put it more pungently in a report to IDA's Board of Trustees on IFD's recent organization:

> "He noted that about 80-90% of dentist practices in the Anderson area is covered by one insurance carrier; therefore *the dentists there believe they need more muscle than organized) dentistry can give them.* (emphasis added) They found that via a union they could go beyond dental association activities. In their opinion *the union movement will not weaken the IDA but will supplement it.*" [296]

103. And finally, according to Secretary Yater, it was important:

> "to give our members a new banner around which to rally and to forge new feelings of unity and purpose." [297]

This last explanation is particularly revealing. It makes clear that the formal organization might be new but the fight and the fighters were the same: they needed only a new banner and rededication to the cause. As IDA's and IFD's public relations counsel put it, "each (has) its separate function" but "*the general purpose of both is the same.*" (emphasis added)[298]

104. These contemporary expressions of the IFD leadership leave no doubt that this organization must

[295] CX 484A-C.

[296] CX 486B.

[297] CX 484A.

[298] CX 476B.

be viewed realistically as a new facet of the same old conspiracy to keep dental X-rays out of insurers' hands which had been carried on by substantially the same dentists lo those many years. Stated conversely, the founders of IFD decided to grasp the banner which, in IDA's hands, seemed in danger of falling. Whether viewed as an "adoption" of IDA's conspiracy or a "continuation" thereof makes no practical difference: IFD had joined IDA in the fight.

105. The "objectives" of this new (IFD) facet of the old (IDA) conspiracy are expressed quite clearly in its state and local constitutions.[299] As noted earlier, IFD's most significant organizational purposes are as follows:

"a.) To represent dentists in all socio-economic matters, negotiations and grievances with employees, third and fourth parties or any group that is involved in financing or delivery of dental care.

* * * * *

b.) To seek to insure adequate compensation and proper working conditions for dentists commensurate with their training and skill and the responsibility they bear for the life and health of their fellow human beings;

c.) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of the highest quality of dental care;

[299] CX 13A-B (State federation); CX 14A-B (Anderson Chapter); CX 15A-B (LaFayette Chapter); and CX 16A-B (Ft. Wayne Chapter).

d.) To associate together all dentists for their mutual benefit and protection;

e.) To unite the efforts of dentists in obtaining and preserving the individual freedom of action necessary for the success of their professional endeavors." [300]

106. Among the methods of achieving these "objectives" which are "contemplated by IFD's Constitution are "*strikes, job actions, boycotts and other forms of economic pressure.*" (emphasis added)[301] Telling the IDA Board of Trustees on 10/1/76 about the recent formation of IFD, Dr. McClure confided that he "hoped they (IFD) would not have to resort to a strike or economic pressure" but that "if they were to be a true union this may become necessary." [302]

107. Membership in IFD is restricted to Indiana-licensed dentists who will "endorse" the above "objectives." [303] A constitutional provision for "discipline" of IFD members includes censure, fine, suspension or expulsion for "valid cause", expressly including, *inter alia*, "failure to conform to the Constitution and By-laws" or "any action detrimental to the welfare of the organization. . . ." [304]

108. The specific embodiment of IFD's policy with respect to X-rays was formally adopted by the membership, after several months study and discussion, on 4/24/77.[305] Known as the "Work Rule," this coun-

[300] CX 13A-B. Also quoted in Par. 2 above.

[301] CX 13Q; CX 14Q; CX 15P; CX 16Q.

[302] CX 486B.

[303] CX 13C; CX 14C, CX 15C; CX 16C.

[304] CX 13T-U; CX 14S; CX 15Q; CX 16R-S.

[305] CX 537A.

terpart of IDA's "Principles of Acceptability" reads as follows:

> "Proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids, with a history and with all clinical findings. No one facet of this process is now, or ever has been recognized by the profession as a substitute for the complete process. To represent otherwise would subject the patient to sub-standard care.
>
> The patient's dentist, therefore, has a *moral and legal responsibility to not allow a determination of his patient's condition to be made for any purpose, without the benefit of a complete examination* which takes into account all of the elements described.[306]

109. IFD's Work Rule does not, as Respondent now contends,[307] merely state a general principle of dental science. The underlined portion above clearly places on a member dentist a duty to *act* to prevent a diagnosis for *any* purpose (thus including a diagnosis for payment of insurance benefits) without a "complete examination" (thus excluding a determination based only on X-rays). This interpretation from the plain language of the Work Rule was confirmed by Dr. Rohn, the movant for adoption of the Work Rule,[308] in a 7/27/78 letter to an insurer that had requested X-rays:

> "Counsel for the Indiana Federation of Dentists, of which I am a member, has advised me that by complying with your demands for diagnostic radiographs and pre-treatment plans for evalua-

[306] CX 537A.

[307] RPF, page 3.

[308] CX 537A.

> tion I could be in violation of the Indiana statutes that regulate the practice of dentistry. Also, Counsel has advised that such practice does contradict the Union Work Rule on such procedure." [309]

110. The application of formal sanctions against dissidents for violation of IFD's Work Rule has apparently been minimal largely because of lack of necessity for such sanctions. In the three areas of Indiana where anti-insurer feeling was strong enough to spawn IFD it is inferable that collective action has been largely voluntary and even enthusiastic on the part of many if not most dentists. Dr. Yater, the dentist who represented Anderson on IDA's Council on Dental Care Programs and became the first Secretary of IFD,[310] confided to the Council's Chairman on 9/8/76:

> "We don't anticipate any holdouts and have kept the retaliatory and economic pressures we could apply to non-members very low key and tried not to threaten any of our members." [311]

111. Shortly thereafter (9/28/76) Dr. Yater nevertheless raised the question of "policy on possible retaliatory gestures and action that could be taken against dissident members." [312] A committee of four, not including Dr. Yater, was appointed to report and recommend upon the question of "such measures that could be taken against dissident members by the Indiana Federation of Dentists." [313]

[309] CX 698. See also CX 674; CX 696 and CX 705.

[310] CX 2C.

[311] CX 484B.

[312] CX 512A.

[313] CX 512A.

112. Two weeks later (10/12/76) the IFD Executive Committee discussed "discipline or acts of reprisal against non-member dentists and dissident members." [314] The minutes read:

> "After lengthy discussion the general consensus was that *lawful severe measures would be instituted only as a last resort*, but that the attorney for the organization should be asked to advise the Executive Committee [concerning] the lawful measures that could be taken in such cases." (emphasis added) [315]

The leadership's silk glove/mailed fist policy to discipline dissidents "only as a last resort" could hardly have brought great cheer to any free spirits among the Anderson dentists. Moreover, that "unity" was to some extent enforced as well as inspired can be inferred from the fact that the few Madison County dentists who did occasionally submit X-rays to CG during 1976-1977 frequently followed up with a phone call asking CG to "make sure that nobody else knew they (X-rays) were in fact submitted. . . ." [316]

Effectiveness Of The Boycott

113. Whether voluntarily or to some extent involuntarily involved, the members of IFD stand committed to a concerted refusal to furnish their patients' X-rays to dental health insurers. Since the offense of trade conspiracy, unlike other kinds of conspiracy, is complete when agreement is reached, with or without commission of any overt acts in furtherance thereof,

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[314] CX 522.

[315] CX 522.

[316] TR 813.

[317] Footnote omitted.

United States v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 225 (1940), we might stop here. In this case, however, there is abundant evidence that IFD has actually carried out the IDA/IFD boycott scheme as planned. Accordingly, we now briefly review its unlawful activities pursuant to the conspiracy already established.

114. The primary evidence on this branch of the case is a number of written refusals by members to submit X-rays requested by insurers, most of them (at least after formal adoption of IFD's Work Rule) in a form recommended by IFD or otherwise linking the refusal to IDA/IFD policy [318] (An illustration of the IFD form is seen in Figure 8).[319] While such evidence is not as comprehensive as the earlier IDA compliance surveys (see Pars. 31 and 34), the written IFD refusals in evidence here are sufficient to show widespread compliance by members with the IDA/IFD boycott policy.

115. Other evidence in this record pictures the operation of the boycott since IFD's formation, from the viewpoint of various insurers, employees and labor unions. We cite two examples.

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[318] CX 622; CX 626; CX 628; CX 633 (*in camera*); CX 637 (*in camera*); CX 641; CX 656; CX 657; CX 658; CX 659; CX 660; CX 661; CX 662; CX 663; CX 664; CX 665; CX 666; CX 668; CX 669; CX 671; CX 672; CX 686; CX 687; CX 688; CX 689; CX 707; CX 709; CX 712; CX 716; CX 722; CX 724; CX 725.

[319] CX 683.

CX ID-683

JAMES D. FREY, D.D.S.
PROFESSIONAL PARK WEST
4600 U.S. Highway 24 West
Fort Wayne, Indiana 46804

April 18, 1978
Insured: Ned J. Boylan
Patient: Patricia Boylan

Dear Sir:

Reference your request for x-rays for the above named patient. It is the policy of this office to provide all diagnostic aids to third parties on an in-office basis and with the consent of the patient. It is my belief that proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids with a history and all clinical findings. No one facet of this process is now, or ever has been, reconginized by the profession as a substitute for the complete process. To represent otherwise would subject the patient to substandard care.

If you will have your consultant contact my office to set up an appointment, I will furnish records and ask the patient to be present for an examination. If you do not feel this is possible, the Indiana Federation of Dentists, of which I am a member, will help you, if possible, to provide a local consultant.

Sincerely,

/s/ James D. Frey, D.D.S.
James D. Frey, D.D.S.

JDF/jg

cc:

patient.

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[Federal Trade Commission Stamp]

116. *Connecticut General/General Motors.* It will be recalled that CG had a "gentlemens' agreement" with IDA (actually with the IDA dentists who later formed IFD) not to insist on dental X-rays for General Motors workers in Indiana.[319] At the time IFD was formed in August 1976 there was concern that CG might be about to breach that agreement [320] and, in fact, in January 1977 CG's Indianapolis office began "testing the waters" by asking for X-rays to determine whether enthusiasm for the boycott might be waning.[321] It quickly found no diminution of enthusiasm.

117. Although not contacted by the IFD member from whom CG had requested the X-rays,[322] CG's manager was called shortly by Dr. Rohn (then Vice President of IFD) and Dr. Pierce, CG's consultant who also sat on IFD's Executive Committee,[323] both checking on whether CG's policy had changed.[324] Thereafter IFD also sent a 3 man delegation to determine whether CG was going to require submission of X-rays,[325] to which the manager responded that CG intended to do so on occasion.[326] The meeting was concluded on such a hostile note that CG's manager refrained from making any further requests for X-

[319] See Para. 74 above.

[320] See Para. 99 above.

[321] TR. 870-872.

[322] Tr. 871, 890-891.

[323] CX 2A; CX 22A-B; Tr. 870-872.

[324] TR 871.

[325] CX 528.

[326] Tr. 873.

rays from Madison County (the Anderson area) for fear of a confrontation which would end all existing cooperation and snarl the payment of GM workers' claims.[327] When CG's manager left the area in November 1977, the submission of X-rays from Madison County was no greater than ever.[328]

118. *Metropolitan/Brockway Glass.* Metropolitan Life Insurance Co. of New York is the group dental health insurer for Brockway Glass Co., a multi-state employer with 450-500 employees in its Madison County, Indiana plant.[329] X-rays are needed by Metropolitan to administer benefits under the alternate benefits feature of Brockway's group dental insurance plan.[330] However, from April 1976 thru at least January 1978 (when the witness left the area) local dentists refused to submit X-rays to Metropolitan and Metropolitan simply declined to pay on claims when X-ray requests were refused.[331] In view of the delay and hardship which this tug of war was causing for Brockway's employees, its Personnel Manager and the President of the local (Glassblowers) union made efforts to talk IFD's Dr. McClure into submitting X-rays but were unsuccessful.[332] When the Personnel Manager left the area in early 1978 the impasse had not been resolved.[333]

[327] TR 877-878.

[328] Tr. 879.

[329] Tr. 1611-1612 Nationally Brockway has 10,000 employees in 13 plants, all covered by the same (Metropolitan) dental care insurance plan. Tr. 1611.

[330] Tr. 1612-1613.

[331] TR 1614-1615, 1635.

[332] TR. 1620 et seq.

[333] Tr. 1638.

119. In summary, the record here abounds with convincing evidence that the IDA/IFD conspiracy to boycott the dental health care insurers serving Indiana has actually been carried out until recently. Continuation of the boycott must be presumed in the absence of proof to the contrary, which has not been made here.[334]

Restraint of Trade

120. Under Section 1 of the Sherman Act, 15 U.S.C. 1, and so under Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, it is *per se* an unlawful restraint of trade for two or more businessmen to *agree* not to deal with another businessman. *Klors Inc.* v. *Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1958). While one businessman may ordinarily decide *individually* that he does not desire to do business with another, *United States* v. *Colgate & Company*, 250 U.S. 300, 307 (1919),[335] "group boycotts or concerted refusals to deal clearly run afoul of § 1 of the Sherman Act." *Times-Picayune* v. *United States*, 345 U.S. 594, 625 (1953). This is true even if the boycott is intended to serve what the boycotters conceive to be a laudatory social purpose, as in the noted case of a boycott against so-called "style pi-

[334] "When the existence of an object, condition, quality or tendency at a given time is in issue, the prior existence of it is in human experience some indication of its probable persistence or continuance at a later period." 2 *Wigmore on Evidence*, 3rd Ed. (1940), § 437, p. 413.

[335] "In the absence of any purpose to create or maintain a monopoly, the (Sherman) Act does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business freely to exercise his own independent discretion as to parties with whom he will deal" (p. 307).

rates". *Fashion Originators' Guild of America, Inc.* v. *Federal Trade Commission*, 312 U.S. 457 (1941). The rationale of the *per se* rule against such concerted refusals to deal is that society will not tolerate private rivals of governmental authority. Except for the statutory exception for labor unions, 15 U.S.C. § 17 and 29 U.S.C. § 52, individuals must generally exercise their economic power individually, not jointly.

121. We have hitherto reviewed in considerable detail the nature and history of the boycott charged here. The evidence has shown that for at least the past decade there has been a largely successful organized effort by IFD, IDA and the members of both, to keep Indiana dentists from submitting requested X-rays to dental health care insurers serving that state and particularly the Anderson, Lafayette and Ft. Wayne areas.

122. That neither IFD nor any dentist member stands in the relation of competitor to any insurer—a point urged by Respondent [336]—is quite immaterial. The target of a boycott need not be a competitor of the boycotter:

> "As the labor-boycott cases illustrate, the boycotters and the ultimate target need not be in a competitive relationship with each other. This (U.S. Supreme) Court also has held unlawful concerted refusals to deal in cases where the target is a customer of some or all of the conspirators who is being denied access to a desired good or service because of a refusal to accede to particular terms set by some or all of the sellers." *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978).

[336] RPF, page 16.

Here there is technically neither a competitor nor a buyer/seller relationship between boycotters and boycottees but there are similar economic relationships susceptible to abuse. The insurers broadly represent the economic interest of the dentists' patients and to that end need access to the patients' X-rays for cost-containment purposes. Group action to shut off [337] insurers' access to the X-rays is precisely the kind of organized economic squeeze play against which the boycott rule is aimed.

123. That would seem to be the end of this case but for a question which has recently evoked much argument and as to which the law is still in an unsettled state: *Do the same antitrust rules apply to professional services as to commodities?* In 1975 the Supreme Court in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 787 (1975) held that professionals are *not*, (as had long been widely believed) [338] entirely exempt from the antitrust laws just because they are professionals. On the other hand, the same opinion suggested that what would constitute a *per se* offense in a trade conspiracy case involving the sale of commodities might require a more extensive economic

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[337] "Shut off" is not too strong a term under the circumstances here. It is true that most dentists have typically expressed their willingness to let insurers' "qualified" experts come to their (the dentists') offices to look at X-rays and other diagnostic aids, (CX 99W). However, there is abundant testimony in this record that that is an empty offer because it is not economically feasible for the insurers to send experts around to each dentist's office (TR 341-42, 924-25, 978, 1121, 1232, 1383-1384, 1457; CX 303E, CX 316).

[338] The point was expressly reserved by the Supreme Court in *American Medical Association* v. *United States*, 317 U.S. 519 (1943), but wishful thinking on the part of professionals long chose to assume there was no problem. See, for example, CX 584D.

investigation (i.e., the "rule of reason" should apply) if professional services are involved:

> "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions concepts which originated in other areas. The public service aspect and other features of the professions may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context be treated differently. We intimate no view on any other situation than the one with which we are confronted today." (pp. 788-89, fn.17)

124. In *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978), the Court warned that this passage from *Goldfarb* "cannot be read as fashioning a broad exemption under the Rule of Reason for learned professions" but did "adhere" to *Goldfarb's* view that:

> "professional services may differ significantly from other business services, and accordingly, the nature of the competition in such may vary. *Ethical norms may serve to regulate and promote this competition and thus fall within the Rule of Reason.*" (p. 696)

125. Assuming, merely for argument, that the Rule of Reason is applicable to the facts of this case, the central question here is *not* whether there are any

pro-competitive factors to be weighed against the *anti*-competitive factors already established.[339] No showing of *any* pro-competitive factor has been made or even attempted by Respondent or the State. The question is rather whether a *non*-competitive factor (i.e., one which affects competitive conditions neither beneficially nor adversely) may be weighed in the balance. Specifically, the claim here is that the boycott in question promotes the health and safety of Indiana citizens by preventing insurers from reducing insurance benefits below proper levels, thereby, as a practical matter, it is alleged, probably preventing an unhealthy reduction in actual treatments, too.[340]

126. The law on whether health/safety factors may properly be weighed in the balance against evidence of anti-competitive tendency is still in process of development and no sure answer can be given. In *Professional Engineers* the Supreme Court seemed to emphasize that generally the *only* evidence admissible in an antitrust case to counter an anti-competitive showing is evidence of a pro-competitive effect:

> "Contrary to its name, the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions." (p. 688)

127. Yet, as just noted, in the same opinion the Court also quoted *Goldfarb's* teaching that: "Ethical

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[339] See discussion in *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 687-692 (1978).

[340] For our scepticism concerning the alleged nexus between reduced payments and reduced treatment, see Par. 148 below.

norms may serve to regulate and promote this competition and thus fall within the Rule of Reason". (p. 696) This pronouncement was footnoted as follows:

> "Courts have, for instance, upheld marketing restraints related to the safety of a product, provided that they have no anticompetitive effect and that they are reasonably ancillary to the seller's main purpose of protecting public from harm or itself from product liability. See, e.g., *Tripoli Co.* v. *Wella Corp.*, 425 F.2d 932 (CA3 1970) (en banc); cf., *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. at 55, n.23." (emphasis added) (p. 696, fn.22)

128. Very recent consideration of the question is found in this Commission's decision in *American Medical Association*, D. 9064 (Slip opinion of 10/12/79 at pages 26 and 37). Announcing that the Commission was not yet prepared to view restraints on professional price advertising as a *per se* offense, Commissioner Clanton wrote:

> "In addition, we recognize that professional services may differ in some respects from other businesses (citing *Professional Engineers* and *Goldfarb*). Arguments suggesting that competition is contrary to the public interest are not cognizable under the rule of reason, but other justifications for ethical norms, such as the facilitation of non-deceptive advertising, may be procompetitive and must be taken into account." (p. 26)

129. Later, after finding certain of AMA's activities to constitute unreasonable restraints of trade

(and so unfair methods of competition) because they bore "little relation" to their professed ethical purpose to "prevent impairment of medical judgment and deterioration of medical care," Commissioner Clanton elaborated as follows:

> "Whatever the extent to which quality of care concerns are cognizable under the antitrust laws. . . . the restraints here go far beyond anything that might be reasonably related to the goal of preventing use of improper medical procedures." (p. 37)

130. It is apparent that the proper role of health/safety evidence in rule of reason restraint of trade cases has yet to be worked out. If, as we have concluded here, a "group boycott" is unlawful per se, the health/safety question need not be answered. If, however, this Commission and the courts continue Commissioner Clanton's preference to treat professional boycott cases under the rule of reason, a rule for health/safety evidence must be settled. Practical considerations point this Administrative Law Judge strongly to consideration of health/safety factors in such a balancing of equities, even if health and safety factors are really neither pro nor anticompetitive.

131. However, this assumes that the health and safety factors are real and not just the overly broad "ethical principles" which Commissioner Clanton eventually decided should properly be disregarded in AMA. In order to determine what, if any, genuine health/safety factors we should consider here under a rule of reason, we turn now to analysis of the deficiencies in Indiana insurers' medical practices alleged by IDA/IFD to justify their members' continuing concerted refusal to submit requested X-rays to such insurers.

The Medical Issues

132. IDA/IFD's campaign to keep Indiana dentists from turning patients' X-rays over to dental health care insurers has always been based principally on IDA/IFD's claim that the insurers rely largely or even solely on X-rays when making diagnoses that should not be made without recourse to *all* available diagnostic aids (including clinical oral examinations, narrative reports and all the bio-chemical tests now available from commercial laboratories). During the IDA stage of the conspiracy that Association's so-called "Principles of Acceptability," adopted by it to support development of "a unified position" regarding to all third party dental plans,[341] included the following provisions:

> "3. X-rays should *not* be provided to any patient or third party.
>
> a. X-rays are part of the dentist's legal health records of the patient.
>
> b. *X-rays alone cannot give a third party sufficient information for diagnosis or treatment planning.* (emphasis added)
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> c. X-rays in the hands of a third party are another interference with the dentist-patient relationship and the dentists's professional judgment." [342]

133. In a "missionary" talk in early 1976, Dr. Dan Rohn, a leading figure during all stages of the boycott, explained the so-called "Indiana Plan" to the

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[341] CX 39A.

[342] CX 39A.

American Academy of Dental Practice Administration:

> "The one principle that causes the most problem is our stand on non-submission of radiographs to a third party. . . . First of all we believe the reading of radiographs and making decisions which would alter a treatment is diagnosing dental disease. This is practicing dentistry. It should be done only by the attending dentist and not from radiographs alone. I am sure none of you here would be presumptious enough to look at a set of radiographs alone and make or alter another doctor's treatment plan. You would want more information than just the radiographs. Any good, responsible dentist would." [343]

134. Following organization of IFD in 1976, a committee set out to draft its "work rules" and among those considered was one expressly opposing dentists' submission of X-rays to insurers. The single "work rule" ultimately adopted, in April 1977, however, referred to non-submission of X-rays only obliquely. It did so by proscribing diagnosis and treatment planning without the assistance of all diagnostic aids, a narrative history and all clinical findings. It then placed on each dentist "moral and legal responsibility" for making sure that his patient's condition not be determined "for any purpose" without just such a "complete examination":

> "Proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids with a history and with all clinical findings. No one facet of this process is now, or ever has been, recognized by the profession as a substitute for the complete process. To represent otherwise would subject the patient to sub-standard care.
>
> The patient's dentist, therefore, has a moral and legal responsibility to not allow a determination of his patient's condition to be made for any purpose without the benefit of a complete examination which takes into account all the elements described (above)." [344]

[343] CX 394F-G.

135. During this trial there was a great deal of expert testimony by practicing dentists, (mostly IFD leaders), insurance company executives (with dental expertise) and two academic experts (from Indiana University) concerning what X-rays can and cannot be expected to reveal for dental diagnostic purposes. The testimony on this complex question is summarized for easy reference in Paragraphs 136 through 139.

136. Complaint Counsel adduced evidence of a good many things which a radiograph *can* reveal to a dentist and much of this went unchallenged by either Respondent or Intervenor. For example, there was no denial of expert testimony by Metropolitan's sometime Director of Dental Relations that an X-ray will show a Dental consultant tooth decay, an abscess, bone loss around the teeth or pathology in the bone itself.[345] Nor was there any dissent from testimony by the same witness that an X-ray can even

[344] CX 537A. See also CX 542B, the back of IFD's standard claim form for patients, with the "Work Rule" printed thereon.

[345] TR 1436-37. But cf. Dr. Janzarik at TR 2548 to the effect that an X-ray may not show decay which is masked by a large silver filling.

spot dental caries that may not be evidenced through clinical examination.[346] An X-ray will also show, he explained, if there are teeth in opposition to teeth that are present (so as to permit determination of whether the teeth have functioning counterparts).[347] He testified, too, that an X-ray will show such physiological attitudes as bone structure around the teeth, affecting degree of mobility (backward and forward movement in the teeth) based on bone support.[348] [Another of Complaint Counsel's experts testified that an X-ray does not show a patient's physiological condition but added that this was of slight importance with respect to the mechanical restoration of teeth.] [349]

137. One area in which there *was* some conflict of testimony concerns occlusion (the striking angle of the teeth). On one hand an Aetna expert asserted that an X-ray can demonstrate the incidence of traumatic occlusion, depending on the scope of the X-ray, the quality with which it is taken and the angle with which it is taken.[350] However, Respondent's current President testified that an X-ray alone will *not* show an occlusion of the teeth and that a diagnosis of occlusion cannot be made from an X-ray, with or without a claim form.[351] Similarly, the Aetna expert testified that an X-ray can show the hardness of a patient's bite (i.e., the pressure exerted) from

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[346] TR 1515.

[347] TR 1514-15.

[348] TR 1514.

[349] TR 323.

[350] TR 1322.

[351] TR 2548-49. Accord: TR 324.

the amount of wear in the occlusal surfaces[352] but another expert put it differently: an X-ray, he said, does *not* show the hardness of a person's bite, unless there is abrasion on the teeth (and even then X-rays may be indecisive about the wear of the cusps).[353] The same Aetna expert testified that such abnormal habits of a patient as pipe-smoking may be shown by an X-ray;[354] but pipe-smoking is *not* one of the conditions to which an X-ray will point, according to one of Respondent's leaders.[355]

138. There were certain areas where there seems to be no serious argument that an X-ray alone will *not* do the job. Respondent's current President asserted without challenge that even a trained dentist can *not* determine the choice of restorative material just by looking at an X-ray, because that choice varies with how well the patient takes care of his teeth, which, in turn, affects how long the restorative material will last.[356] Another of Respondent's leaders testified that he would refuse to try and determine from looking at an X-ray what choice of restorative material he should use in his treatment, because "there are so many extenuating conditions." [357]

139. Finally and not too surprisingly, there was general agreement that X-rays will *not* show the patient's mental condition,[358] which is said to have con-

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[352] TR 1322-23.

[353] TR 325.

[354] TR 1323-24.

[355] TR 2448.

[356] TR 2547.

[357] TR 2447.

[358] TR 326, 1324-25, 1514, 2549.

siderable bearing on the treatment."[359] Respondent's current President elaborated on this as follows:

> "(A)s you are working with a patient, you are more aware of what they will tolerate and what they will not tolerate and what they will take care of and what they will not take care of.
>
> A typical example is a patient who is missing tooth on each side of one arch and what I would say is the best treatment is two unilateral bridges. All right. Cheaper but adequate is a partial. But if this patient is the type that does not really give a darn about his teeth and yet he does brush them—I mean he just doesn't take meticulous care—the partial is a food trap. . . . The least (costly?) adequate or alternate mode would be a partial and yet it would destroy the dentition of the patient's mouth."[360]

140. In addition to all the technical testimony about what a dental X-ray will or will not reveal, there was conclusionary testimony as to whether a dental diagnosis should ever be based solely on X-rays (or any other diagnostic aid). On this question the experts—on all sides—seemed to agree that an X-ray or other diagnostic aid alone is not enough for an accurate diagnosis.

141. Professor Kasle, for the Intervenor, testified that no one diagnostic aid is sufficient in and of it-

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[359] TR 1324-25.

[360] TR 2549-50. But cf. the testimony of a California Dental Service expert who conceded that X-rays will not show a mental condition and agreed that oral hygiene is very important but "would not necessarily prescribe a different type of filling material because the oral hygiene of the patient was questionable." TR 326-27.

self for a proper diagnosis and more specifically that "a radiograph can't stand alone."[361] A Connecticut General dental consultant said he would have to have additional information beside X-rays before he would invoke alternate treatment: "I cannot make a complete determination from an X-ray."[362] A top Aetna dentist/executive agreed: "I would say that diagnosis should not be made on the basis of X-rays alone."[363]

142. To say, however, that diagnoses should not rest on X-rays alone does not take the argument very far. How much else is required for a sound determination in the circumstances of a particular case? Respondent's current President not surprisingly would require the use of all diagnostic aids for all determinations:

> ". . . . [S]omeone who is to determine what is right and what is wrong in each particular case must see everything clinically [physically], health history, X-rays and the patient."[364]

143. Literally applied, such a rule, requiring physical examinations in all cases, would seem to put the insurers out of the dental health care insurance business in Indiana because it is "very, very costly" and "unpractical" to perform a physical examination on

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[361] TR 2716-17.

[362] TR 947.

[363] TR 1302.

[364] TR 2546. The head of Indiana University's Radiology Department was even more expansive (TR 2716).

each patient [365] and examinations are "not a practical solution." [366]

144. More realistic was the opinion of the head of IU's Dentistry School, who would utilize every diagnostic aid available [367] but agreed that it would probably be "proper" to base a diagnosis on a claim form and an X-ray or a claim form and a narrative history, if necessary.[368]

145. An even more pragmatic approach is that of the pioneer California Dental Service, whose longtime head testified here that in "the great majority" of California's more expensive cases [369] his organization makes its decision on the basis of X-rays but will make a physical examination if a question about the determination is raised by the attending dentist.[370] Only in less than 1 percent of its predetermination (more expensive) cases does California Dental Service find it necessary to supplement X-rays with physical examination.[371]

146. Unfortunately the record here is substantially deficient in evidence as to just what supplementation

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[365] TR 341-42, 924-925, 978, 1221, 1232, 1383-1384, 1457; CX 303E, CX 316.

[366] TR 1220.

[367] TR 2692.

[368] TR 2690. This testimony was based on a rephrased question and it is not clear on which basis the question was answered.

[369] A $100 minimum predetermination guide is apparently usual, although inflation seems to be driving the minimum up to $125 (TR 393, 534-36, 563-64, 980).

[370] TR 339-41, 354.

[371] TR 339-41.

of X-rays for diagnoses is the usual practice of the dental health care insurers serving Indiana. That deficiency is plainly the fault of Respondent, which has the burden of establishing that its restraint of such insurers' trade is reasonable.

147. Not knowing how the public health and safety are being affected by the insurers practices here, we have no health/safety factor to weigh in the balance against the plain anticompetitive and anti-consumer tendencies of Respondent's "group boycott". Our condemnation of the second paragraph of Respondent's vigilante "Work Rule" [372] and Respondent's application thereof stands.

148. This disposition of the health/safety question makes it unnecessary to deal with Respondent's constant assumption that an insurer's change (generally downward) [373] in benefit payments translates automatically into a comparable change in treatment plan. The record contains no satisfactory evidence that this is usual. Even if it were, we would have difficulty tracing the change in treatment plan to the change in benefit payments. The patient is always free to make up the difference in cost between what his own dentist recommends and what the insurer's consultant will approve. The patient is thus an independent, intervening force breaking the asserted chain of causation between disallowance of a claim and change in treatment plan.

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[372] CX 537A.

[373] There is no argument that most changes are reductions. An Aetna survey in its Ft. Wayne regional office, for example, found 20 alternate course reductions in 21 referrals (TR 1351-52).

State Action

149. Respondent's chief defense here (and the reason for the State of Indiana's intervention) concerns "state action". The tenth amendment to the Federal Constitution reserves to individual states all powers neither expressly nor impliedly [374] granted to the Federal government and the Supreme Court has recently interpreted the 10th Amendment quite favorably to the states.[375] Many years ago, in *Parker* v *Brown*, 317 U.S. 341 (1943) the Supreme Court held that the Sherman Act was never intended by Congress to reach state action regulating intrastate commerce, even though such regulation be anti-competitive in character and thus would be in violation of the federal law against unreasonable restraints of trade if it had been undertaken by a private person (and had the requisite effect on inter-state commerce).

150. A recent trilogy of cases has tightened up the doctrine of *Parker* v. *Brown* in certain respects, notably by insistence on finding *real* action by a state or private action really required by a state before honoring such a defense.[376] While the basic rule of

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[374] The *implication* of powers to the Federal government was one of the major advances of the Constitution over the Articles of Confederation, which, in a similar context, reserved to the states all powers not *expressly* granted to the Federal government. The tenth amendment uses neither the word "express" nor the word "implied". Corwin, E. S., *The Constitution of the United States of America*, 88th Cong., 1st Sess., Senate Document No. 39 (1964), page 1035.

[375] *National League of Cities* v. *Usery.*, 426 U.S. 833 (1976).

[376] *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579 (1976); *Bates* v. *State Bar of Arizona*, 433 U.S. 350 (1977); *City of Lafayette, Louisiana* v. *Louisiana Power & Light Co.*, 435 U.S. 389 (1978).

Parker v. *Brown*—that real state regulation of commerce is not a restraint of trade under the Sherman Act—remains intact, nonetheless the genuineness of the state action or state requirement of private action relied on has become a prime issue whenever such a defense is raised.

151. In this case Respondent and Intervenor rely on the "state action" doctrine to defend Respondent's boycott of insurers as a way of enforcing the Indiana law against unlicensed practice of "dentistry". On this branch of the case no attack is made on alleged over-reliance by insurers' dental consultants on X-rays for diagnosis; the attack is rather entirely on the use of lay screening by X-rays. The theory seems to be that insurers break the Indiana law against unlicensed practice of dentistry when they employ unlicensed paraprofessionals to make "diagnoses" from radiographs, even if only for the limited preliminary purpose of "screening", to determine which, if any, X-rays need be sent to an insurance company dental expert for definitive review. That alleged offense, the argument goes, plus Indiana's law against aiding and abetting the commission of such an offense requires Respondent and its dental vigilantes to boycott the insurers. We must accordingly review Indiana's "state action" on the subject.

152. In 1913 the Indiana Dental Law made it unlawful for any person to "practice dentistry" in Indiana who had not first obtained a license to do so, as provided in the same statute. Indiana Code 25-14-1-1 (in IX 4). The statute provided that the Governor appoint from a list of practicing dentists, submitted by the trustees of the Indiana Dental Association, a nine-man state board of dental examiners. I.C. 25-14-1-2 *et seq.* (in IX 4). This state board of dental examiners was charged by the same statute

with "administering and enforcing the laws pertaining to the practice of dentistry and of dental hygiene" and it was given the power and authority "to make, promulgate, adopt and enforce rules and regulations for the administration and enforcement of this act, in the manner provided by the law regarding the adoption of rules and regulations by a state agency". I.C. 24-14-1-13 (in IX 4). The "manner provided by the law" etc. is now set forth in I.C. 4-22-2-2(a) of the Indiana Administrative Procedure Act as follows:

> All rules,[377] regulations and other documents containing a statement of policy, other than official opinions of the Attorney General, which the issuing agency [378] intends to have the effect or force of law but which are not promulgated, approved and filed as rules in conformity with the provisions of this chapter, shall be invalid, void and of no force or effect after the first day of January, 1978.[379] (footnotes added).

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[377] The statutory definition of a "rule" includes "any rule, regulation, standard, classification, procedure, or requirement of any agency . . . interpreting, supplementing or implementing any statute." Ind. Code Ann. § 4-22-2-3 (Supp. 1979) (Burns).

[378] The statutory definition of an "agency" includes any board or department of the State of Indiana. Ind. Code Ann. § 4-22-2-3 (Supp. 1979) (Burns).

[379] Ind. Code Ann. § 4-22-2-2(a) (Supp. 1979) (Burns), as set forth above, replaced the following language:

> All rules and regulations heretofore made, adopted or promulgated by any agency of the State of Indiana which were not promulgated, approved and filed in conformity with the provisions of chapter 213 of the Acts of 1943, shall be invalid, void and of no force or effect after the first day of January, 1946.

153. Section 4-22-2-5 similarly provides, in pertinent part, that "[n]o such rule shall be effective until after compliance with the provisions of this act." The decisional law of Indiana has long been fully in accord. Thus, statements and bulletins issued by state agencies that are not properly promulgated as rules have no legal effect. *Indiana State Personnel Board* v. *Jackson*, 192 N.E.2d 740 (Ind. 1963); *State* v. *Edwards*, 89 N.E.2d 443 (Ind. 1950). The act requires that before any rule or regulation having the force of law is adopted, there be notice and a hearing in which interested persons can participate and that the rules be approved by the Governor and Attorney General within a specified time period and filed with the Secretary of State.[380]

154. The Indiana Dental Law gives the State Board of Dental Examiners the right to place the holder of a license on probation or suspend or revoke his license for any of numerous specified causes, such as obtaining a license by fraud, conviction of a felony, "unprofessional conduct" (of many specified kinds) or failing, neglecting or refusing to obey and comply with any Indiana statute in regard to the practice of dentistry or using or employing in his practice the services of anyone who is violating any provisions of any Indiana statutes relating to dentistry. I.C. 24-14-1-19 (in IX 4).

155. In addition to possessing this power to suspend or revoke existing licenses for specified causes the Board of Dental Examiners, along with the Attorney General, local prosecuting attorneys and citizens of the same county is empowered by the Indiana Dental Law to obtain an injunction against the prac-

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[380] I.C. 4-22-2-4, 5 (Burns Supp. 1979).

tice of dentistry "as herein defined" by anyone not possessing a valid license to do so. I.C. 25-14-1-14 (in IX 4). The definition of "practicing dentistry" within the meaning of the Dental Law appears in I.C. 25-14-1-23, which includes, among several other tests, the following:

> "Any person . . . who . . . offers to diagnose or professes to diagnose or treats or professes to treat any of the lesions or diseases of the human oral cavity, teeth, gums, maxillary or mandibular structures. . . ."

156. It is worth noting that this provision does not purport to deal with "diagnosis", as distinguished from an "offer" or "profession" to diagnose and a fairly good argument might, perhaps, be made that the statute was never intended to reach mere diagnosis, absent a holding out as a dentist. However, this section of the law also contains a proviso which does use the word "diagnosis" without qualification:

> "Provided that this section shall not apply to those procedures which a legally licensed and practicing dentist may delegate to competent office personnel as to which procedures the dentist exercises direct supervision and full responsibility, which procedures shall in no event include either (1) those procedures which require professional judgment and skill such as diagnosis and treatment planning. . . ." I.C. 25-14-1-23 (in IX 4).

Accordingly, we must conclude that the "practice of dentistry", as defined in I.C. 25-14-1-23, was meant to include the simple act of "diagnosis", whether or not accompanied by an offer or profession to diagnose.

157. On the other hand, the same proviso would seem to imply that diagnosis is a non-delegable function of dentistry *only* insofar as it is one of those procedures "which require professional judgment and skill." That leaves open the question whether the very limited kind of "diagnosis" made by a paraprofessional in screening X-rays to determine whether or not to refer a particular radiograph to an expert should be deemed "diagnosis" within the meaning of the law against unlicensed practice of dentistry.

158. Whatever the practice in former years, insurers serving Indiana now generally allow lay employees to view X-rays only for the limited purpose of deciding whether there is a problem that seems to call for expert judgment, i.e., whether to rely on the attending dentist's opinion as a basis for payment or to send the X-rays to the insurer's own experts for a second opinion.

159. A paraprofessional may process a "simple form . . . the more common procedures" which represent the overwhelming portion of claims.[381] Since, however, the paraprofessional can only allow—i.e., cannot reduce or deny—the claim, it is hard to see how an insured can ever be prejudiced in such case.[382]

160. If, however, there is a question a paraprofessional cannot handle, he or she has no authority to deny or reduce the claim but must send it on to a company dentist for expert review.[383]

161. A concrete example of how another major insurer serving Indiana deals with this problem is

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[381] TR 913-914, 1320.

[382] TR 2704-05, 2725-26.

[383] TR 1416.

found in a claims guide for internal company use.[384] It recognizes that "it requires a professional consultant to read and interpret X-rays for other than the most evident conditions "(specifying several)[385] and thereafter lays down the general rule as stated above:

> "A lay processor or analyst, upon review of X-rays, can approve benefits BUT . . . . NO PERSON OTHER THAN A CONSULTANT CAN RECOMMEND THAT BENEFITS BE REDUCED OR DENIED." [386]

Association et al. v. *Commonwealth of Pennsylvania Insurance Department* Pa. Cmwlth., 398 A2d 729 (1979), the Commonwealth Court held that a dental health care insurer would not violate Pennsylvania's statute against unauthorized practice of dentistry by having a lay clerk make a "first review" (i.e., a *screening*) of radiographs to determine whether they satisfy the insurer's standards. The applicable statute provided that "a person engages in the 'Practice of Dentistry' within the meaning of this act who diagnoses . . . any disease, pain or injury . . . of the human teeth, jaws or associated structures . . . (etc.)" 63 P.S. § 121. The testimony was "clear" that if a clerk decides that the radiographs do not satisfy Blue Shield standards, the radiographs are then forwarded to a dental examiner for a "final" determination. The Court concluded:

> "Appellants have not indicated to us, and we are unable to ascertain for ourselves, any aspect of

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[384] IX 500A-C.

[385] IX 500B (*in camera*).

[386] IX 500C (*in camera*).

> the practice of dentistry as defined in Section 2 (i.e., 63 P.S. § 120) which is violated when a clerk makes the first review of radiographs to determine whether they satisfy Blue Shield standards." page 734.

The Supreme Court of Indiana seems no more likely than the Commonwealth Court of Pennsylvania to find that the word "diagnosis" applies to the mere screening of X-rays by paraprofessionals for subsequent analysis by experts who possess "professional judgment and skill." Accordingly on this record there is probably no violation of the law against unlicensed practice of dentistry to be "aided and abetted" by sending X-rays to insurers.

163. Even, however, if we were one hundred percent wrong about whether an insurer's paraprofessionals "practice dentistry" within the meaning of the Indiana Dental Act, merely by screening X-rays and even if Respondent's dentists were found to be aiding and abetting the insurer's offense *individually* just by sending them X-rays on request, nevertheless the result of this case would be the same. Nothing in the Dental Act suggests either expressly or by implication that dentists are permitted—much less *required*—to organize a group boycott to help enforce the law—the only offense with which Respondent is charged here.

164. The Act is quite clear about how and under what circumstances public force is to be mobilized to deal with the unlicensed practice of dentistry. We have already referred to the Dental Act's provision for obtaining an injunction against the unlicensed practice of dentistry. I.C. 25-14-1-14 (in IX 4). It is true that such an injunction may be sought not only by the public prosecutors and the Board of Den-

tal Examiners but by "any citizen of any county" where the unlicensed dentistry is alleged to be carried on. A citizen's injunction suit, however, is a horse of a different color from a privately organized vigilante movement.

165. The Indiana injunction statute specifically provides that such an action shall be maintained "in accordance with the laws of the State of Indiana governing injunctions," I.C. 25-14-1-14 (in IX 4) with all the fair-trial and rational-proof safeguards inherent in judicial procedure. In such an action the methods used by insurers must be proved by reliable evidence and a reviewable decision must be carefully reached as to whether the precise facts shown really amount to "practicing dentistry." It would be hard to believe that the Indiana legislature—after setting up such procedural safeguards for an accused—intended to allow a dental vigilante group to enforce the law on its own by way of an organized boycott, free from all the restraints that civilization has built into judicial injunction procedure.

166. The contrast between law enforcement and vigilantism is even more striking in the case of criminal proceedings against unlicensed practice of dentistry and/or "aiders and abettors" thereof, which is provided in the Indiana Dental Act, I.C. 25-14-1-25. Is it even conceivable that the organizers of a private boycott would or could apply the presumption of innocence, the reasonable doubt rule and the criminal law's many other refinements to the random mass of unsubstantiated facts and rumors on which vigilantes commonly act? Vigilantism may have played a useful role in the pioneer West when no other kind of law enforcement was yet available—but the lights

of civilization are now presumably brighter than that. The Indiana Dental Law makes clear provision for *public* action to stop the unlicensed practice of dentistry. It does not contemplate and certainly does not *require* concerted private action of any kind.

167. When we look beyond Indiana's statutes on the subject of practicing dentistry without a license, we find a few purported administrative actions (by the Board of Dental Examiners and the Department of Insurance) to which Respondent and Intervenor point as filling the statutory gap. The effort of Respondent and Intervenor to find valid administrative action of this sort is strenuous but not convincing. We now review these efforts.

168. The first evidence on which Respondent and Intervenor rely is an "Unofficial Advisory Letter" dated 3/14/74 from then Deputy Attorney General C.C. Plopper to the President of the Indiana Board of Dental Examiners.[387] It was written in response to a request from the Board to know whether unauthorized practice of dentistry is involved in "clerks employed by third party insurance companies, checking radiographs submitted by a dentist to determine if the proposed treatment by the dentist should be authorized," Plopper replied:

> "No clerk, who would be a layman, could possess the knowledge required to make such a diagnosis from radiographs. Neither would such a clerk have the knowledge to determine whether a proposed treatment would be proper, so that it would fall within authorized bounds.
>
> It is my opinion that only a dentist should review radiographs and proposed treatments for

[387] IX 5.

third party insurance companies and the use of clerks to make such reviews would be improper and should be proscribed." [388]

169. The Plopper letter shortly thereafter became the basis for a general statement of policy by the Board of Dental Examiners [389] and later in the year (10/9/74) the Board advised at least one dental health insurer (Aetna) that it was "taking this (the Plopper) position." [390] Some four years later, after the X-ray boycott had resulted in the bringing of this complaint, the Board sent a letter to all Indiana dentists reviewing I.C. 25-14-1-23's definition of "practicing dentistry", citing the relevant criminal law, including I.C. 25-14-1-25 (unlicensed dental practice a misdemeanor) and I.C. 335-41-2-4 (aiding and abetting commission of a crime), and reaffirming (almost verbatim) the gospel according to Plopper (with reference to submitting dental X-rays to dental health insurers).[391] There is no evidence, however, that the Attorney General of Indiana or anyone else has ever charged—let alone convicted—any layman of practicing dentistry without a license on the ground that such person screened X-rays for a dental health care insurer.

170. Plopper himself recognized that "the views expressed herein [i.e., in his 'unofficial advisory letter' of 3/14/74] are those of the writer and are not to be considered to be the opinion of the Attorney General of Indiana nor a precedent of the Attorney

[388] IX 5.

[389] IX 6.

[390] IX 90A.

[391] IX 9, IX 9A, IX 9B.

General's office." [392] Plainly Mr. Plopper's personal opinion has something less than binding force and constitutes something less than "state action".

171. The policy statements of the State Board of Dental Examiners that resulted from Plopper's letter fare little better. Such policy statements are "invalid, void and of no force or effect unless promulgated, approved and filed as rules" in conformity with the provisions of the State Administrative Procedure Act, I.C. 4-22-2-2(a). See also I.C. 4-22-2-5. That statute requires notice and hearing in which interested persons can participate; approval of the rules by the Governor and Attorney General; and filing with the Secretary of State. I.C. 4-22-2-4 and 5.

172. However, the Board of Dental Examiners never held any hearings, issued any rules or regulations, undertook any administrative proceedings or brought—or even recommended—any enforcement suits concerning submission of X-rays to and review of X-rays by insurers.[393] While it is perhaps understandable that Respondent's allies on the Board of Dental Examiners would prefer merely to issue policy statements rather than hold hearings where insurers, customers and customers' employees would all have to be heard, mere policy statements by individuals in public office are not "state action".

173. Neither Plopper's "unofficial advisory opinion" nor the Board of Dental Examiners' policy statements based thereon had any standing at law; until recently neither even had application to the

[392] IX 5. Only "official" opinions of the Attorney General have the force of law under Section 4-22-2-2 of the Indiana Administrative Procedure Act.

[393] TR 2229, 2281, 2291-93, 2778.

factual situation that has emerged from the evidence here. Plopper expressly assumed a practice by insurers of having clerks check X-rays "to determine if the proposed treatment [394] by the dentist should be authorized." This evidence here shows, however, that this is *not* the prevailing practice among insurers of dental health serving Indiana. Such insurers' paraprofessionals read X-rays only to screen out the large number which need not be referred to one of the insurer's "dental consultants" for expert examination and determination.[395] Even if Plopper's opinion had had legal standing insofar as applied to a lay diagnosis for treatment or payment, it had no application to a lay determination merely as to whether an expert opinion was called for. Both the Plopper letter and the Board's policy statements are thus immaterial here.

174. We turn now to the Indiana Department of Insurance, which has plenary authority over any unfair claim practices of insurance companies operating in that state.[396] State Insurance Commissioner H. P. Hudson, head of the Insurance Department during recent years, put in a good deal of time and effort trying to mediate between the IDA/IFD dentists and the dental health insurers serving Indiana. The high point of his efforts at mediation was reached during the first half of 1976, when he planned and promoted a nine-months pilot program for submission of X-rays by dentists to insurers under compromise con-

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[394] We trust that Plopper understood he was giving an opinion on authorization of payment, not authorization of treatment.

[395] See Pars. 158-162, above.

[396] CX 810E.

ditions, the whole to be monitored by his office.[397] The insurers agreed to try the pilot program [398] and Hudson then made a personal appeal to the House of Delegates of IDA on 5/1/75 [399] but the dentists refused to compromise.[400]

175. Mediation, however, is very different from state action. Indeed, since it merely encourages the parties to settle a dispute voluntarily it could well be thought of as the opposite of state action. As for evidence of Hudson's participation in the dispute in a governmental capacity—hearing and deciding insurance claim practice cases or otherwise—such evidence is close to zero.

176. Typical is the Indiana Insurance Department's "Bulletin 37" on the subject of "Dental X-rays",[401] issued in early or mid-September 1979 [402] on the eve of hearings in this case. Bulletin 37 first recited previous advice to insurance companies offering dental insurance plans that the practice of allowing personnel not licensed as dentists to "evaluate" dental X-rays is a violation of the insurance laws of Indiana governing Unfair Trade Practices and the Indiana Dental Licensing Law (I.C. 25-14-1-1 *et seq.*) It further recited that "allegations are being made that certain insurance companies are currently

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[397] CX 810B.

[398] CX 810C.

[399] See Hudson's speech to IDA outlining his proposal in CX 810 *et seq.*

[400] CX 425.

[401] IX 167.

[402] TR 2774-75.

utilizing personnel not licensed as dentists to evaluate dental X-rays. Over Commissioner Hudson's signature, Bulletin 37 then made this pronouncement:

> "The Department reiterates and reaffirms its position opposing such practice. Evidence brought to my attention reflecting this conduct will result in an unfair trade practice hearing against the company so charged." [403]

177. It appears, however, that the Commissioner's bark is notably worse than his bite, as cross-examination of his assistant and legal adviser developed at the trial here:

> "Q. (W)hat status does a bulletin issued by the Department of Insurance have?
>
> A. A bulletin is the Department's position on whatever the subject matter is of that bulletin and the Department takes the stance that that bulletin will be enforced by the Department. It does not carry the weight of either statute or regulation but [it] is an interpretation that the Department makes with regard to the subject matter.
>
> Q. It has no force of law, is that correct?
>
> A. That's correct.
>
> Q. And this bulletin was not issued pursuant to—no notice to the public to comment on this bulletin or hearings were held prior to its issuance, was there?
>
> A. That's correct." [404]

[403] IX 167.

[404] TR 2777.

178. One other Insurance Department/Dental Board policy statement deserves most careful consideration. Hearings in this matter began on 10/2/79. On that date, in response to an urgent request by the Attorney General's office and the Board of Dental Examiners to issue a strong pronouncement for the FTC proceeding.[405] Insurance Commissioner Hudson and Dr. Paul Stephens, long member of the IDA/IFD X-ray conspiracy and by 1979 President of the all-dentist Board of Dental Examiners, together signed a letter addressed to "all Indiana-Licensed Insurers" which was sent to all Indiana-licensed dentists, too.[406] This policy statement re-hashed the Plopper opinion, recited that "the use of radiographs in any diagnostic capacity whatsoever requires judgment and skill reserved only for licensed dentists," explained how a dentist's submission of X-rays to insurers "aids and abets" the unlicensed practice of dentistry and warned of possible criminal prosecution for such a violation. Thus far there was nothing very new in the letter.

179. However, there was enclosed with the letter a form affidavit [407] to be sent by dentists to insurers and returned with a sworn statement by the insurer that the dentist's X-rays have been "*screened, read, used for 'benefit determination' and/or any other*

[405] A Board member informed the Insurance Department: "The Attorney General's office is most anxious for these documents to be mailed before October 2 as they want to use them for exhibits in the FTC case" (CX 826A). He reported to the Attorney General's office: "Hopefully the Department of Insurance and the Board will get copies in the mail to their respective charges by October 2. At any rate the letter could be dated September 24 (CX 827).

[406] IX 167 and IX 167A.

[407] IX 167B through IX 167D.

diagnostic procedure" only by specified licensed dentists. Obtaining such an affidavit was recommended to protect the dentist from criminal prosecution as an "aider and abettor" of the insurer.[408] The theory of this affidavit was expressly stated in the text, as follows:

> "Should an insurance carrier be subsequently suspected of using unlicensed personnel to perform any but the clerical operations of identifying the source or disposition of films, that carrier will be subject to investigation and potential prosecution. *Operations termed 'benefit determination', screening, reading, identifying teeth or any such procedures are deemed to be reserved for licensed dentists only.*" (emphasis added)[409]

180. Note that this last-minute effort to aid and abet Respondent's "state action" defense for the first time sought to bring mere *screening* of X-rays within the target area of the Indiana Insurance Department/Board of Dental Examiners attack. That the letter went out in response to a plea by Intervenor's Counsel to help win this case[410] would alone cast grave doubt on its significance as evidence of "state action". Be that as it may, under cross-examination Commissioner Hudson's legal advisor conceded "that (the Hudson/Stephens joint letter) *does not have the force of law.*" (emphasis added)[411] Under the provisions of Indiana's little APA cited above, he could

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[408] IX 167C.

[409] IX 167A.

[410] CX 828.

[411] TR 2778.

hardly have said anything else for it is obvious that Respondent and its allies on the Dental Board and in the Insurance Department were hard pressed enough just to get out of the purported evidence of "state action" wanted by Respondent's counsel for this hearing without going through the lengthy hearings and public debate required to make a real rule in Indiana.

181. The testimony of the same official confirmed that the Insurance Department has never held hearings or promulgated formal rules or regulations with respect to the question of submission of radiographs to insurance companies.[412] Indeed, he explained, the Department has never been engaged in any legal proceeding over the issue of radiographs[413] nor have any of the unfair trade practice actions it has brought against insurance companies in the past related to any matter pending here.[414]

182. As a matter of fact in August 1978 Respondent itself was so dissatisfied with what it then considered the substantial failure of the State of Indiana and its Board of Dental Examiners to employ the unauthorized practice provisions of the State's Dental Practice Act the Respondent wanted that it (IFD) brought suit against both the State and the Board in the U.S. District Court for the Southern District of Indiana (Civil No. IP 78-498-C) for $25 million damages.[415]

183. However, in December 1978 a deal was apparently made for Respondent to drop its suit if the

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[412] TR 2778.

[413] TR 2778.

[414] TR 2782.

[415] CX 508A, D, E, F.

State Board of Dental Examiners would agree to intervene in this (FTC) matter.[416] On 12/20/78 the District Court, Holder, J., granted Respondent's motion to dismiss its own suit and the following day the State filed its petition to intervene here.[417]

184. To summarize the "state action" question, the State of Indiana has long required dentists to be licensed but the Dental Practice Act specifies nothing as to whether paraprofessionals should be forbidden either to read X-rays or to screen them for reference to experts.

185. Occasional assertions of some state-officials to the effect that X-rays should not be read by laymen for any purpose and, during trial here, to the effect that X-rays should not even be screened by laymen all turn out to lack official standing to define an offense. Without a primary offense of practicing dentistry without a license there can, of course, be no secondary offense of "aiding and abetting" the primary offense. Manifestly Indiana dental health care insurers are not required to conform their business practices to the mere personal opinions of Dr. Stephens or Commissioner Hudson any more than to the "unofficial advisory opinions" of Mr. Plopper.

Collateral Estoppel

187. A principal contention of Respondent and Intervenor is that we are not permitted to make our own assessment of the "state action" defense, as we have just done. Such consideration is foreclosed under the well-known doctrine of "collateral estoppel", the argument runs, by the prior findings and conclusions of a U.S. District Judge in a suit brought by

[416] CX 824.

[417] See Summary of Proceeding above, pp. 4, 5, 6.

the State of Indiana and its Board of Dental Examiners to compel this Commission to permit them to intervene in this matter.

188. Under the traditional "mutuality" requirement of the collateral estoppel doctrine Respondent probably could not invoke that doctrine here because Respondent was not a party to the intervention suit.[418] In any event, however, the doctrine of collateral estoppel does not apply for another reason. The findings which Respondent and Intervenor urge us to carry over from the suit to compel allowance of intervention were not necessary or essential to the judgment of intervention, a universally accepted prerequisite to application of collateral estoppel.

189. The most recent restatement of the law by the American Law Institute provides:

> "§ 68. *Issue preclusion—General Rule*
>
> When an issue of fact or law is actually litigated and determined by a valid and final judgment, *and the determination is essential to the judgment* (emphasis added), the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim." [419]

Comment h thereto elaborates on the portion underlined above:

[418] *Restatement of Judgments* (1942) § 93. But cf. *Restatement (2d) of Judgments*, § 88 (Tent. Draft No. 2, 1975) eliminating the mutuality requirement for application of collateral estoppel. See *Haize* v. *Hanover Ins. Co.*, 536 F.2d 576, 578, fn. 1 (1976).

[419] *Restatement of Judgments*, 2d (Tent. Draft No. 4, 4/15/77) § 68.

> "*Determinations not essential to the judgment. If issues are determined but the judgment is not dependent upon the determinations, relitigation of those issues in a subsequent action between the parties is not precluded* (emphasis added). Such determinations have the characteristics of dicta and may not ordinarily be the subject of an appeal by the party against whom they were made. In these circumstances, the interest in providing an opportunity for a considered determination, which if adverse may be the subject of of an appeal, outweighs the interest in avoiding the burden of relitigation." [420]

190. The rule that a finding unnecessary to a judgment does not raise a collateral estoppel has been unquestioned federal law for over a century. The Supreme Court held in *Russell* v. *Place*, 94 U.S. 606, 608-09 (1876) that:

> "to render the judgment conclusive, it must appear by the record of the prior suit that the particular matter sought to be concluded was necessarily tried or determined—*that is, that the verdict in the suit could not have been rendered without deciding that matter* (emphasis added) or it must be shown by extrinsic evidence, consistent with the record, that the verdict and judgment necessarily involved the consideration and determination of the matter."

191. In order to apply this law to the relevant facts it is necessary to review briefly the record here and the nature and history of the extraneous lawsuit where the findings in question were made. Following

[420] *Ibid.*

issuance of this complaint against Respondent Indiana Federation of Dentists in the Fall of 1978 the State of Indiana and its Board of Dental Examiners, by its Attorney General, on 12/29/78 petitioned to intervene here to insure an adequate presentation of Indiana's position on the "state action" question.

192. The Commission's rule concerning intervention (§ 3.14) provides little light on when intervention is justified. It provides:

> "§ 3.14 Intervention.—Any individual, partnership, unincorporated association, or corporation desiring to intervene in an adjudicative proceeding shall make written application in the form of a motion setting forth the basis therefor. Such application shall have attached to it a certificate showing service thereof upon each party to the proceeding in accordance with the provisions of § 4.4(b) of this chapter. A similar certificate shall be attached to the answer filed by any party, other than counsel in support of the complaint, showing service of such answer upon the applicant. The Administrative Law Judge or the Commission may by order permit the intervention to such extent and upon such terms as are provided by law or as otherwise may be deemed proper."

193. The Administrative Law Judge, citing the tests laid down in *Firestone Tire & Rubber Company*, D. 8818, 77 F.T.C. 1666 (1970), on 1/5/79 denied the petition to intervene (although welcoming any *amicus curiae* briefs). He did so primarily because no showing had been made that Respondent would not adequately present the State's position and there was thus no countervailing consideration to weigh against the likely evil effects of complicating and lengthening the proceeding by permitting intervention.

194. On 1/19/79 the State of Indiana applied to the Commission for review of the Judge's order but on 2/5/79 the Commission, too, denied intervention, primarily for failure to demonstrate how the State would likely improve on the showing to be made by Respondent. On 3/12/79 the Commission denied a petition for reconsideration and soon thereafter the would-be intervenor turned to the Federal courts.

195. On 5/23/79 the State of Indiana and the Indiana State Board of Dental Examiners filed in the U.S. District Court for the Southern District of Indiana, Indianapolis Division, a complaint (with motion for preliminary injunction) against the United States of America and this Commission, which was then docketed as Civil No. IP-453-C.[421] Reciting the history of Indiana's unsuccessful attempts to intervene in this case and pleading various facts relative to the "state action" defense here, the State's complaint ended by asserting (Par. 46) that the State of Indiana was "entitled to intervention as of right in FTC Docket 9118 pursuant to its sovereign right to regulate the dental profession within the State."

196. The prayer for relief which followed, however, did not limit itself to *intervention* but sought, alternatively, an order *dismissing the FTC Complaint for lack of jurisdiction*:

> "Wherefore, the State of Indiana and the Indiana State Board of Dental Examiners respectfully request that the Court issue an Order:
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> a) enjoining the F.T.C. from proceeding further, in any way, with the prosecution of docket 9118 until the resolution of the instant complaint;

[421] IX 1000Z-25 et seq.

> b) finding that the F.T.C. lacks jurisdiction to proceed with docket 9118, and order that the cause be dismissed; or, in the alternative,
>
> c) declaring that the State of Indiana was wrongfully denied its intervention of right in docket 9118, and order that full intervention be granted immediately; and
>
> d) for all other just and proper relief." [422]

197. On 5/23/79 the United States and this Commission filed a motion (with supporting brief and proposed findings and conclusions) to dismiss this complaint or, in the alternative, for summary judgment on the grounds that (1) the District Court lacked jurisdiction over the subject matter; (2) that the complaint failed to state a claim; and (3) that there was no genuine issue of material fact and defendants were entitled to judgment as a matter of law.[423] On 7/10/79 the District Judge set 7/19/79 for a hearing and argument on the *State's* motion for a preliminary injunction but when counsel appeared the District Judge expressed distaste for preliminary injunctions and stated his preference to proceed immediately to trial on the merits under F.R.C.P. Rule 65, to which proposal all counsel agreed. The Judge had Commission counsel orally admit or deny each allegation of Indiana's complaint, then proceeded to hold an immediate hearing on the merits, which consisted of submission of a few affidavits and general agreement that a few others could be submitted within a few days. The case was thereupon submitted for decision. [The entire record of the hearing, which

[422] IX 1000XX.

[423] IX 1000Z-11.

occupies only 57 pages, is in evidence here for easy reference.[424]

199. What followed is complicated. The District Judge had no hesitation in denying without opinion the Commission's motion to dismiss Indiana's complaint or in the alternative for summary judgment and did so on 8/17/79.[425] On the same date the District Judge made findings and conclusions generally taken from Indiana's proposals,[426] and then by mistake entered *both* of the two judgments which had been proposed by Indiana as *alternatives*.[427]

200. One judgment signed by the District Judge ordered the Commission to "immediately grant plaintiff State of Indiana's petition for leave to intervene in the Federal Trade Commission proceeding." [428] The second judgment signed by the District Judge ordered the Commission to "immediately cease exercising jurisdiction and dismiss the Federal Trade Commission proceeding." [429] It is plain, as recognized in Indiana's original prayer for "alternative" relief,[430] that it would be inconsistent to order *both* the dismissal of the proceeding and the intervention of Indiana at the same time.

201. The mistake in entering both proposed judgments was promptly recognized and corrected *sua*

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[424] See CX 855A through CX 855Z-35 (hearing transcript) and IX 1000G (Court's entry for 7/19/79).

[425] IX 1000Z-4.

[426] IX 1000Z-5 through IX 1000Z-10.

[427] IX 1000Y.

[428] IX 1000U.

[429] IX 1000V.

[430] IX 1000XX.

sponte by the District Judge on 8/23/79 by adding the following entry concerning the 8/17/79 judgment of dismissal for lack of jurisdiction:

> "The above Judgment is vacated as improvidently entered in the belief it was a copy of a Judgment entered the same date. The Judgment permitting intervention of August 17, 1979 is in full force and effect." [431]

202. This left it that the only surviving *judgment* was the one compelling intervention. However, it also left a number of *findings and conclusions* proposed by Indiana and adopted by the District Judge which would tend to support a dismissal but would be unnecessary if not positively irrelevant to the intervention order. Accordingly, on 9/7/79 the Commission filed a motion to vacate certain findings and conclusions *nunc pro tunc* to conform to the modified judgment.[432]

203. The *findings of fact* by the District Judge which the Commission wanted vacated were specified to be as follows:

> "(11) Indiana Code 25-14-1-23 and 25 define the criminal act of practicing dentistry without a license, which includes the diagnosing or reading of X-rays." [433]
>
> . . . . . .
>
> (18) Under the mandate of Indiana Law, Indiana dentists are prohibited from submitting their dental X-rays to third party in-

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[431] IX 1000Y.

[432] IX 1000H-J.

[433] IX 1000Z-7.

surers who employ "dental consultants", who are not licensed to practice dentistry to read or diagnose the X-rays." [434]

204. The *conclusions of law* by the District Judge which the Commission wanted vacated were specified to be as follows:

"(3) The order proposed by the Secretary of the F.T.C. would infringe on the State's right to regulate the practice of dentistry within the State under its police powers by the Tenth Amendment to the Constitution of the United States (citing cases).[435]

. . . . . .

(6) The F.T.C. is proceeding beyond its jurisdiction in attempting to regulate the practice of dentistry in the State of Indiana and should be enjoined from doing so (citing cases)." [436]

205. The merest reading of these particular findings and conclusions—all of them going to the merits of the case here—makes it plain that they were originally proposed to support the demanded dismissal of this case on "jurisdictional" grounds and are quite irrelevant or immaterial to the demand for intervention, which turns entirely on procedural considerations and which Judge Holder had already found supportable in his conclusion of Law #5.[437]

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[434] IX 1000Z-9.

[435] IX 1000Z-10.

[436] IX 1000Z-10.

[437] "The State meets the requirements for intervention as established by the F.T.C. in the *Firestone Tire & Rubber Company*, Dkt. No. 8818, 77 F.T.C. 1666, 1669 (1970) in that the issues the State seeks to raise cannot be properly raised and argued by the current parties to the proceeding and only minimal additional cost and time will be required by its intervention." (Conclusion of Law #5).

The rest of the District Judge's conclusions are clearly *unnecessary* to the only judgment (intervention) rendered by him and accordingly should have been vacated when the other (mistaken) judgment of dismissal was vacated.

206. However, the Commission's motion to vacate was *not* granted. In an entry on 10/18/79 the District Judge made an explanatory statement, which is reproduced here as Figures 8A-B,[438] to the effect that the Commission "has jurisdiction over certain of the matters and of the Indiana licensed doctors before it" but asserted on the other hand that "that jurisdiction is limited by the exclusive rights of the State of Indiana under the police power to protect the health of the citizens of Indiana and oversee the dental profession." "It is this right," he explained, "that the defendants are enjoined from invading. . . ." (See Figures 8A and 8B).

207. The rest of the statement is difficult to follow and seems little more than a general expression of sympathy for the State's position on the merits here. While closing with an assurance that "the Federal Trade Commission is unhampered by this Court's ruling of August 17, 1979 in fulfilling its mission in Docket No. 9118" he nonetheless added: "The findings of fact as found and the conclusions of law thereon are necessary for the relief sought." How findings on the merits of this lawsuit could be nec-

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[438] IX 1000E-F.

essary to a judgment in that lawsuit merely allowing intervention here the District Judge did not attempt to explain and we cannot convince ourselves that such could be the case.

208. Respondent and Intervenor now take the position that the District Judge's express statement that his findings were necessary to his judgment is dispositive. But this is contrary both to authority and common sense. Thus a judge's characterization of his judgment as made on the merits is not binding when objective analysis indicates otherwise:

> "Although the court which renders the judgment states that it is 'on the merits,' this characterization is not always conclusive in the forum or on other courts which are reguired to give full faith and credit to the judgment. Nor for purposes of *Erie-Tompkins* is the characterization by the state courts of its judgment as procedural or jurisdictional binding upon the federal courts sitting in that state, which are required to determine independently what is 'substantive' for purposes of the *Erie* doctrine." 1B *Moore's Federal Practice*, ¶ 0.409[7] at 1041-1042 (2d Ed., 1974).
>
> "It is well settled . . . that *what has been adjudicated is to be determined not from the opinion rendered but from a consideration of the judgment actually entered in reference to the issues* presented for decision." *Adams* v. *Pearson*, 411 Ill. 431, 104 NE 2d 267, 270 (1952) (emphasis added).
>
> "The intention of the court to make a determination on the merits may be important *but if the judgment is clearly not on the merits, the court's*

> *intention to make it a bar is immaterial.* The words 'with prejudice' add nothing to the effect of the judgment in such a case, no matter what light they throw on the intention of the court." *Goddard* v. *Security Title Ins. and Guarantee Co.*, 83 P.2d 24, 28 (Cal., 1938) (emphasis added).

209. Such cases merely reflect common sense: no judicial *ipse dixit* can make black white. There being no serious doubt that the District Judge's findings and conclusions about the merits of this case were not *necessary* to his only *judgment* (allowing intervention), the case is clearly governed by the rule of § 68 of the Restatement of Judgments (2d) denying collateral estoppel where a determination is "not essential to the judgment." Our conclusions above with reference to the doctrine of "state action" and its inapplicability here thus correctly stand on their own two feet, unshackled by the District Judge's expressions of feeling about the merits here.

* * * * *

The findings of fact proposed by Complaint Counsel, Respondent and the State of Indiana are all granted insofar as consistent with this Initial Decision and denied insofar as inconsistent herewith.

FIGURE 8A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

No. IP 79-453-C

STATE OF INDIANA; and
INDIANA STATE BOARD OF DENTAL EXAMINERS

vs.

THE UNITED STATES OF AMERICA;
FEDERAL TRADE COMMISSION; and
MICHAEL PERTSCHUK, Chairman, PAUL RAND DIXON,
ELIZABETH HANFORD DOLE, DAVID A. CLANTON,
and ROBERT PITOFSKY, Members of Federal
Trade Commission

ENTRY

The matters of the defendants' September 7, 1979 motion to vacate nunc pro tunc certain findings of fact and conclusions of law to conform to modified judgment as amended on October 9, 1979 to show belated service of motion on plaintiffs' counsel, and plaintiffs' motion to strike came on for the Court's ruling.

The Court having considered the matters and being duly advised in the premises, now finds that defendants' motion should be and is hereby DENIED and plaintiffs' motion to strike is MOOTED by such ruling.

Simultaneously herewith the Court if filing a CORRECTED judgment entry of August 17, 1979.

It is apparent that the Federal Trade Commission has jurisdiction over certain of the matters and of the Indiana licensed dentists before it. On the other hand that jurisdiction is limited by the exclusive rights of the State of Indiana under the police power to protect the health of the citizens of Indiana and oversee the dental profession. It is this right that the defendants are enjoined from invading and impressing upon the State of Indiana's citizens of an agreed course of conduct between a group of dentists and the Federal Trade Commission in which the State of Indiana had no input. The agreement between the Federal Trade Commission and one group of Indiana dentists no doubt will be in issue in the hearing as the complaint in Docket No. 9118. Indiana's ability to prosecute a dentist would be greatly hampered by such a course of agreed action. The power of the purse of the payers acting through unlicensed, incompetent personnel could be the ultimate deciding factor in the diagnosis of an Indiana citizen's need for dental care. It should be clear that the mission of the Federal Trade Commission is not limited to the complainant payers' and Indiana's licensed dentists points of view but also respect the rights of the sovereign State of Indiana and thus avoid complainant payers' and/or Indiana's licensed dentists use of the Federal Trade Commission proceeding to circumvent the State of Indiana's policing the dental profession in the interest of the health of its five million citizens. The Federal Trade Commission is unhampered by this Court's ruling of August 17, 1979 in fulfilling its mission in Docket No. 9118. The findings of facts as

found and the conclusions of law thereon are necessary for the relief sought.

Dated this 18th day of October, 1979.

/s/ Cale J. Holder
CALE J. HOLDER
Judge
United States District Court
Southern District of Indiana

IV. CONCLUSIONS OF LAW

1. The Federal Trade Commission has jurisdiction over the subject matter of this Complaint against unfair methods of competition and unfair acts and practices, by virtue of the provisions of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

2. The Commission has personal jurisdiction over Respondent unincorporated association and its members by virtue of the delivery of a copy of the Complaint to its office at 2403 Raible Avenue, Anderson, Indiana, on 11/13/78, pursuant to Rule § 4.4(a)(iii).

3. Although Respondent is an unincorporated association, for purposes of Section 4 of the Federal Trade Commission Act, 15 U.S.C. 44, it is a "corporation" organized to carry on business for the profit of its members.

4. Respondent is not in the business of insurance and even if the targets of its organized boycott be deemed in the business of insurance, the McCarran-Ferguson Act's exemption of the insurance business from the antitrust laws expressly excludes application of the exemption to a boycott of the business. 15 U.S.C. 1012, 1013(b).

5. Respondent has billed itself as a labor union or labor organization and thus exempt from the strictures of the antitrust laws under Sections 6 and 20 of the Clayton Act, 15 U.S.C. §§ 17, 29, but it is not such a labor organization and its activities are not exempt from antitrust scrutiny.

6. While the businesses of dentists that make up this association are not in interstate commerce, the practices charged in this Complaint tend to have an adverse effect on the businesses of dental health care insurers serving Indiana, which are in interstate commerce.

7. Respondent was formed in 1976 to join and continue a concerted refusal by many dentists in Indiana to submit radiographs (X-rays) to dental health insurers either automatically or on request.

8. The concerted refusal of Respondent and its co-conspirators to supply X-rays to dental health care insurers on request is *per se* an unreasonable restraint of trade within the meaning of Section 1 of the Sherman Act, 15 U.S.C. 1, and an unfair method of competition and an unfair act and practice under Section 5 of the Federal Trade Commission, 15 U.S.C. 45.

9. Even if such a concerted refusal were not an unreasonable restraint of trade *per se*, there is no proof on this record of any pro-competitive effect and no sufficient proof of any beneficial or effect on health/safety to outweigh the plainly anticompetitive and anti-consumer effects of the IDA/IFD group boycott of dental health care insurers.

10. Respondent and its co-conspirators have also threatened to prevent and to some extent have prevented said insurers from getting access to the services of dentist members except on Respondent's terms, as an ancillary weapon in the struggle over submission of X-rays.

11. Respondent's continuing effort to organize refusals by dentists to supply X-rays requested by insurers is volunteered activity and has never been required by the State of Indiana. Respondent has no "state action" defense here.

12. The findings and conclusions of the U.S. District Court for the Southern District of Indiana, Holder, J., in *State of Indiana* v. *Pertschuk, et al.* (Civ. IP 79-453-C) raise no collateral estoppel here and do not operate to deprive this Commission of jurisdiction over this matter.

13. Respondent has violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

14. The relief to be granted here will be in the public interest.

V. Relief

The relief contemplated in the notice attached to the Complaint is recited verbatim in the Summary of Proceedings above.[439] However, Complaint Counsel, as is entirely proper, now recommend following the somewhat different IDA consent order (Attachment A to "Complaint Counsel's Brief Supporting Conclusions of Law") and point to testimony that "this (IDA) order has been effective against IDA."[440] Even Respondent concedes that "all (insurance) companies apparently experienced a substantial increase (in X-ray submissions) in late 1978 after a consent order was agreed to between the IDA and the FTC and the IDA changed its (X-ray submission) policy."[441] However, Respondent's concession may be undue; the transcript references cited in support refer only to "an increase", not to "a substantial increase."[442] Whether the IDA consent order has really freed up Indiana X-rays significantly is not quite as clear as counsel on both sides would make out.

In any event it is our responsibility to decide what seems most likely to put an end to the violation found, *F.T.C.* v. *Ruberoid Co.*, 343 U.S. 470, 473 (1962) with the least dislocation possible, *F.T.C.* v. *All-Luminum Products, Inc.*, 63 F.T.C. 1268, 1279

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[439] See Page 4 above.

[440] TR 922; TR 1282.

[441] RPF #12.

[442] TR 919, 922, 1282.

(1963) and to that purpose we have broad discretion, *Jacob Siegel Co.* v. *Federal Trade Commission*, 327 U.S. 608, 611 (1946), so long as the remedy is reasonably related to the offense, *Federal Trade Commission* v. *Ruberoid Co.*, 343 U.S. 470, 473 (1952). We shall now take up the several operative paragraphs of the IDA consent order one by one.

Paragraph IIA of the proposed order goes to the heart of the case, prohibiting IFD from intentionally organizing dentists to refuse to submit X-rays or other diagnostic aids to third-party insurers. Since the principal finding of this proceeding is that Respondent has done precisely what Paragraph IIA(1) would forbid, there can be no objection of substance to this proposal.

Paragraph IIA of Complaint Counsel's proposed order also contains a second sentence which would direct IFD to cease and desist from organizing dentists to "refuse to deal in any particular way with any one or more third-party payers (*i.e.*, insurers)". This concern to forestall other boycotts for other purposes by members of an association already found to be boycott-prone is entirely reasonable, although we have revised the wording somewhat in our own order.

The Administrative Law Judge has made one important change in Par. IIA. The proposed order assumes that IFD will remain in existence as an unincorporated association. The Judge sees no good reason for keeping this association in existence as such. Not an ordinary professional association carrying on the usual gamut of professional activities and services like IDA, IFD was conceived simply as a "labor union" *front* for those IDA members (particularly those living in the Anderson, Lafayette and Ft. Wayne areas) who were most concerned with keeping

IDA's boycott of dental health insurers alive, even after antitrust prosecution began to loom as a real threat. With our decision forbidding the members of IFD to continue their insurer-boycott, the reason for IFD's being ceases and its continued existence could serve only as a constant temptation to use the organizational shell for the old, meretricious purpose or something like it.

Dissolution of an *ad hoc* organization designed as a vehicle to carry on a venture unlawful under the antitrust laws is the oldest known form of antitrust divestiture. Dissolution of the holding company thru which a monopoly had been effected was the very heart of the relief in *Standard Oil Co. of New Jersey* v. *United States*, 221 U.S. 1 (1911). Accordingly, the very first provision of our order here will be to order dissolution of IFD within six months and a report to the Commission not more than a month later. In this situation our several cease and desist orders will be directed to the members of IFD rather than to the unincorporated association which has served as the vehicle for their unlawful activities and will therefore shortly cease to exist under our order. It is, of course, well established that the Commission can issue orders which are binding on unnamed officers, agents, representatives and employees. *Western Fruit Growers Sales Co.* v. *F.T.C.*, 322 F.2d 67 (9 Cir., 1963) cert. den. 376 U.S. 907 (1964); *Mandel Bros.* v. *F.T.C.*, 254 F.2d 18, 22 (7 Cir., 1958), rev'd on other grounds, 359 U.S. 385 (1959). *A fortiori* as to members of an unincorporated associations sued in the association's name.

Paragraph IIB of Complaint Counsel's proposed order would forbid IFD to compel or coerce insurers to change any provision of a dental health care bene-

fits program. This situation seems covered by the provision of our own order [(2-(2))] just discussed. Accordingly we omit recommended Paragraph IIB.

Paragraph IIC would apparently prohibit activity by Respondent which has either of two purposes:

1. inducing patients to choose dentists who do *not* "cooperate" with dental health insurers; or
2. influencing patients to choose dentists on the basis of how such dentists do not "cooperate" with insurers.

The provision seems aimed at consumer-level boycotts but it is abstruse and unclear. The key word "cooperate", which could mean many things, is not defined and its presence would make the provision quite difficult to enforce. Moreover, there would usually seem to be little need for this kind of auxiliary prohibition if the association be dissolved and the members be forbidden to pursue the insurer-boycott which is the gist of this case.

Moreover, the only [443] cited evidence in this record that IFD has ever tried to mount anything like a boycott at the consumer level is a single incident in the latter part of 1977 and early 1978 involving "Arnie's Pizza King" in Lafayette, Indiana.[444] When the Lafayette chapter heard that "Arnie" was posting a list of "accepted" and "non-accepted" dentists in

[443] We are at a loss to understand how Complaint Counsel's reference to the Anderson chapter's monopoly of orthodontists and oral surgeons in that area could bear on this particular provision and have accordingly disregarded Complaint Counsel's reference to that fact.

[444] CX 544A; CX 547.

Lafayette for its employees' reference, IFD's Dr. Fontaine either was deputized or volunteered (the record is not clear) to "discuss removing the list with the owner." [445] Some months later IFD's *Union News* reported with reference to an unidentified restaurant in Lafayette (which we assume to be "Arnie's") that "it was good to hear that a simple phone call from the IFD remedied the situation." [446] The record does not show whether Dr. Fontaine in his phone call engaged in any threats of economic or other pressure or simply relied on a personal friendship or took some other approach unrelated to a boycott threat; nor do we have any evidence of why "Arnie" took down his list.

It seems to the Administrative Law Judge that a broad prohibition of consumer-level boycotts such as would be forbidden by recommended Par. IIC should not be based on a single, isolated minor incident (about which we really know very little.) Accordingly we exclude recommended Par. IIC or any equivalent from our order.

The last two provisions of Complaint Counsel's proposed order (Paragraphs II-D and II-E) might well be called the "Pierce clauses" for both seem to be aimed at practices involving, among others, Dr. Pierce, the dentist nominated by IDA to be a consultant for CG but who always remained loyal to IDA and IFD. Paragraph II-D of Complaint Counsel's proposed order would prohibit IFD from trying to induce insurers to select certain dentists as dental consultants for any reason but their expertise, while Paragraph II-E would prohibit IFD from trying to influence dental consultants to render opinions which

[445] CX 544A; CX 547.

[446] CX 563B.

they do not really believe. Complaint Council find need for these provisions firstly because the evidence shows IFD "pressuring" CG to make reluctant use of their candidate (Dr. Pierce) to review claims in the Anderson area and secondly because Dr. Pierce was, as we have said, a strong IFD supporter who hardly ever requested other dentists' X-rays or even visited local dentists' offices to review X-rays there for CG.

The half dozen dental consultants involved here were the product of a compromise between IFD and CG when the GM-UAW plan started and the compromise somehow kept CG operating in Indiana despite the formidable opposition of the IDA/IFD conspiracy. For various reasons the idea of having IDA nominate these experts to CG (to decide difficult benefit questions) happened to serve the interests of both parties. This case was not brought to test Dr. Pierce's faithfulness or faithlessness. Efforts to deal with such minor, incidental matters in a Commission order dedicated to freeing up a substantial business beset by an unlawful boycott serve only to confuse the point of the exercise and, accordingly, we decline to be side-tracked into putting "Pierce clauses" in our own order.

ORDER

The Administrative Law Judge now finds that issuance of the following ORDER will serve the public interest:

1. All members of the unincorporated association and component chapters known as the Indiana Federation of Dentists shall henceforth cease and desist from associating themselves together in that organization and the officers of the association shall take all

steps necessary to effect its complete dissolution within six months from the date of this order, reporting the details of such dissolution to this Commission in writing within one month thereafter.

2. All persons who have at any time since 8/24/76 been members of the Indiana Federation of Dentists shall henceforth cease and desist from expressly or impliedly agreeing among themselves or with other dentists to:

(1) refuse collectively to submit patients' dental radiographs (or any other diagnostic aids) to dental health insurers who, with the patients' consents, request such radiographs; or

(2) refuse collectively to deal with anyone in order to force their will on the target of such boycott.

3. Respondent will forthwith mail a copy of this decision and order by registered mail to every member of the association at his last known address.

/s/ Paul R. Teetor
PAUL R. TEETOR
Administrative Law Judge

March 24, 1980

[SECTION 5 OF THE FEDERAL TRADE COMMISSION ACT]

Sections 5a-c of the Federal Trade Commission Act, 15 U.S.C. 45a-c, provide:

(a)(1) Unfair methods of competiiton in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful.

(2) The Commission is hereby empowered and directed to prevent persons, partnerships, or corporations, except banks, savings and loan institutions described in section 18(f)(3), common carriers subject to the Acts to regulate commerce, air carriers and foreign air carriers subject to the Federation Aviation Act of 1958, and persons, partnerships, or corporations insofar as they are subject to the Packers and Stockyards Act, 1921, as amended, except as provided in section 406(b) of said Act, from using unfair methods of competition in or affecting commerce and unfair or deceptive acts or practices in or affecting commerce.[6]

Proceeding by Commission; modifying and setting aside orders

(b) Whenever the Commission shall have reason to believe that any such person, partnership or corporation has been or is using any unfair method of competition or unfair or deceptive act or practice in or affecting commerce, and if it shall appear to the Commission that a proceeding by it in respect thereof would be to the interest of the public, it shall issue and serve upon such person, partnership, or corporation a complaint stating its charges in that respect and containing a notice of a hearing upon a day and at a place therein fixed at least thirty days after the service of said complaint. The person, partnership,

or corporation so complained of shall have the right to appear at the place and time so fixed and show cause why an order should not be entered by the Commission requiring such person, partnership, or corporation to cease and desist from the violation of the law so charged in said complaint. Any person, partnership, or corporation may make application, and upon good cause shown may be allowed by the Commission to intervene and appear in said proceeding by counsel or in person. The testimony in any such proceeding shall be reduced to writing and filed in the office of the Commission. If upon such hearing the Commission shall be of the opinion that the method of competition or the act or practice in question is prohibited by this Act, it shall make a report in writing in which it shall state its findings as to the facts and shall issue and cause to be served on such person, partnership, or corporation an order requiring such person, partnership, or corporation to cease and desist from using such method of competition or such act or practice. Until the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, or, if a petition for review has been filed within such time then until the record in the proceeding has been filed in a court of appeals of the United States, as hereinafter provided, the Commission may at any time, upon such notice and in such manner as it shall deem proper, modify or set aside, in whole or in part, any report or any order made or issued by it under this section. After the expiration of the time allowed for filing a petition for review, if no such petition has been duly filed within such time, the Commission may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any report or order made or issued

by it under this section, whenever in the opinion of the Commission conditions of fact or of law have so changed as to require such action or if the public interest shall so require, except that (1) the said person, partnership, or corporation may, within sixty days after service upon him or it of said report or order entered after such a reopening, obtain a review thereof in the appropriate court of appeals of the United States, in the manner provided in subsection (c) of this section; and (2) in the case of an order, the Commission shall reopen any such order to consider whether such order (including any affirmative relief provision contained in such order) should be altered modified, or set aside, in whole or in part, if the person, partnership, or corporation involved files a request with the Comission which makes a satisfactory showing that changed conditions of law or fact require such order to be altered, modified, or set aside, in whole or in part. The Commission shall determine whether to alter, modify, or set aside any order of the Commission in response to a request made by a person, partnership, or corporation under paragraph (2) not later than 120 days after the date of the filing of such request.

Review of order; rehearing

(c) Any person, partnership, or corporation required by an order of the Commission to cease and desist from using any method of competition or act or practice may obtain a review of such order in the court of appeals of the United States, within any circuit where the method of competition or the act or practice in question was used or where such person, partnership, or corporation resides or carries on business, by filing in the court, within sixty days from

the date of the service of such order, a written petition praying that the order of the Commission be set aside. A copy of such petition shall be forthwith transmitted by the clerk of the court of the Commission, and thereupon the Commission shall file in the court the record in the proceeding, as provided in section 2112 of title 28, United States Code. Upon such filing of the petition the court shall have jurisdiction of the proceeding and of the question determined therein concurrently with the Commission until the filing of the record and shall have power to make and enter a decree affirming, modifying, or setting aside the order of the Commission, and enforcing the same to the extent that such order is affirmed and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public or to competitors pendente lite. The findings of the Commission as to the facts, if supported by evidence, shall be conclusive. To the extent that the order of the Commission is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the Commission. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the Commission, the court may order such additional evidence to be taken before the Commission and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The Commission may modify its findings as to the facts, or make new findings, by reason of the additional evidence so taken, and it shall file such modified or

new findings, which, if supported by evidence, shall be conclusive, and its recommendation, if any, for the modification or setting aside of its original order, with the return of such additional evidence. The judgment and decree of the court shall be final, except that the same shall be subject to review by the Supreme Court upon certiorari, as provided in section 240 of the Judicial Code.[7]

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 192-A-B]

WEST CENTRAL EXPLORER

For The Preservation Of The
Doctor-Patient Relationship

PRESENTING AN OVERVIEW OF THE RADIOGRAPH ISSUE IN INDIANA

Why Consider The Radiograph Issue At All?

The importance of the radiograph issue is increasing largely due to the fact that some *40%* of all Indiana citizens are now covered by some form of insurance. Component societies located in areas where large contracts are now in force have been among those experiencing the greatest pre-payment difficulty. This difficulty is the result of poor insurance company contract language for their cost control purposes.

Some Indiana dentists, either in ignorance or in an attempt to gain economic advantage over their peers, have been forwarding radiographs to insurance carriers. This unethical practice puts increasing pressure of a monetary nature on dentists who practice in the same geographic areas. Continued over long periods of time, this has caused some ethical dentists to comply with third party demands in spite of their desire to remain loyal to the Indiana Plan.

Many dentists who remain loyal to the Indiana Plan now are actively seeking relief from the harsh economic realities they face due to the unethical behavior of other dentists who practice in and around their geographic areas.

Recent developments concerning the adopted Texas Dental Association Manual on Third Party Guidelines

have given some I.D.A. leaders and others new hope for resolving the radiograph issue in Indiana. The Texas Plan resembles the Indiana Plan with the exception that it contains provisions for *Designated Consultants* as well as qualified consultants. The following description is taken directly from the Texas Plan:

Dental Consultants

The Texas Dental Association recognizes the availability of two types of dental consultants to be used by dental pre-payment plans to aid in benefit determination under their respective plans.

A. Qualified Consultant

A licensed Texas dentist either employed by or on a retainer by an insurance company writing dental pre-payment plans in the state of Texas.

Qualifications:

1. May or may not be a member of the Texas Dental Association.
2. May review permanent records in the office of the dentist.

B. Texas Dental Association Designated Consultant

A licensed Texas dentist selected by his local component society for purposes of benefit determination of pre-payment programs within the jurisdiction of his component society.

The Texas Dental Association designated consultant is not to be unused for routine determination of eligibility or extent of coverage, this should be done by the third party, utilizing in-

formation taken from the Uniform Claim Form. The T.D.A. designated consultant should be utilized *only* in these rare cases in which a more detailed understanding of the treatment is needed.

Qualifications:

1. Must be a member of the Texas Dental Association.
2. May receive copies of permanent records in his office to aid in benefit determination when deemed necessary by him.
3. Must be selected by his local component society.
4. Each component society will select at least one T.D.A. designated consultant per fifty society members, or no less than two consultants per society.
5. Selections will be for two year staggered terms.
6. The chairman or his designee shall be responsible for equal distribution of claim referrals.
7. Presently, there will be no compensation to the T.D.A. designated consultant.
8. T.D.A. designated consultant use may be denied if abused.
9. All copies of patients' records shall be returned to the dentist promptly. Copies of records may not be sent to any party other than another T.D.A. designated Consultant.

A Comparison Of The Current Situation In Texas And Indiana

One must remember that the Texas Plan, and the Texas designated consultant were instituted very recently (October 1975). The Texas Plan and its designated consultant represents a novel but as yet unproven approach to the pre-payment—radiograph issue.

The recent Bell Telephone contract in Texas has proven interesting. The Texas insurance commissioner has demanded that this contract be tested for a three month period (Jan. 1-Mar. 1, 1976) under Texas Guidelines. Naturally we must view these experiments with interest.

As yet, *no insurance company* has given the I.D.A. any *written assurance* of greater co-operation if the Indiana Plan is modified in any way. Still, there are those who will jump in the bath without first testing the water.

Should The I.D.A. Consider Modifying The Indiana Plan?

If So These Are The Considerations:

All conscientious dentists view radiographs as one of several aids to total diagnosis. Most insurance carriers use them as their *only* aid to "diagnosis" (benefit determination). If the I.D.A. permits its own consultants to use radiographs as their only diagnostic tool, the Indiana Plan will lose much of its credibility. Therefore, we must emphasize that radiographs should only be used as one aid in determining to what extent the procedures recommended by the attending dentist are covered by the plan. (i.e.—a tooth is missing therefore a bridge would be reasonable)

Appeasement never has helped in any conflict, but merely postpones the confrontation. Indiana has been in a position of national leadership in developing new concepts in dental pre-payment. Indiana dentists want continued opportunity to provide a high level of care for their patients.

Dentists who now send films to insurance carriers in violation of I.D.A. policy may continue to do so since it will still be the *path of least resistance* and the way to the *greatest personal financial gain.*

What If The I.D.A. Does Experiment?

The Following Criteria Should Be Met Before Any Change Is Permitted.

1. The I.D.A. should have a *written statement of endorsement* from the insurance commissioner.
2. The I.D.A. must have a *written statement of compliance* with the approved consultant plan by insurance companies covering central care.
3. The I.D.A. will support a patients benefit determination, made by an approved I.D.A. consultant provided—
   a. The I.D.A. approved consultant does not suggest alternate methods of treatment but limits his efforts to determining if the procedures are covered under the contract between the carrier and the insured.
   b. If the I.D.A. consultant cannot, after examining the pretreatment estimate and the radiographic aid, reach such a decision he contacts the attending dentist and attempts to secure enough information to make the decision.

c. If the I.D.A. consultant cannot, after reviewing the records submitted and after consulting with the attending dentist, make a decision as to the liability of the contract, he must submit the case to peer review and agree to base the benefit determination on the decision of the I.D.A. Peer Review Committee.

d. When submitting a patient's personal dental records to peer review, the insurance companies I.D.A. approved dental consultant must provide the committee all the material and information he has received from the attending dentist with an explanation why he has not been able to determine the liability of the contract.

West Central Dental Society
thanks you for considering these issues

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 39-A-B]

INDIANA DENTAL ASSOCIATION
A Constituent of the American Dental Association
1013 Hume Mansur Building
317-638-1341
Indianapolis, Indiana 46204

August 11, 1971

To: Indiana Dental Association Members

Dear Doctor:

As we noted in our June 30 letter regarding the International Harvester-United Auto Workers-Aetna Dental Plan, a follow up letter would be sent by the Aetna Life Insurance Company. That letter has been mailed by Aetna—dated July 1, and delivered about August 1. It explains the details of the dental benefit coverage and the plan's administrative procedures.

As we pointed out in our June 30 letter, the administrative procedures of this plan are *not* in accord with the Indiana Dental Association's Principles of Acceptability; and we urged then and now that all I.D.A. members follow the Association's principles. These principles were adopted by the House of Delegates to support the development of a unified position relating to all third party dental plans. The International Harvester-U.A.W.-Aetna Dental Plan is no exception.

1. *Uniform Claim Form* adopted by the Indiana Dental Association October 1, 1967 is still the form of choice; however, the Council on Dental Care Programs is considering a modified version of this form as adopted by the American Dental Association and Health Insurance

Council June, 1971. In any event, the use of one common form will simplify paper work for the dentist and his assistant.

2. *Processing the completed form*
   a. provide the patient with the completed form who will in turn forward it to the union or insurance claim office for reimbursement.
   b. receive payment for dental service directly from the patient.
3. *X-rays* should *not* be provided to any patient or third party.
   a. X-rays are part of the dentist's legal health records of the patient.
   b. X-rays alone cannot give a third party sufficient information for diagnosis or treatment planning.
   c. X-rays in the hands of a third party are another interference with the dentist-patient relationship and the dentist's professional judgment.
4. *Pre-authorization (pre-determination)* by a third party is *not* in accord with I.D.A. Principles of Acceptability.
   a. pre-authorization interferes with the normal dentist-patient relationship.
   b. pre-authorization interferes with the dentist's professional judgment.
   c. pre-authorization that alters the attending dentist's treatment plan makes the dentist responsible for treatment designated by a third party.

The Issac Knapp District Dental Society is to be complimented on their all-out support of the I.D.A. Principles of Acceptability. A special meeting of the Society was held recently to discuss the details of the International Harvester-U.A.W.-Aetna Plan and to point out where its administrative requirements were a deterrent to good dental procedures. A follow up telephone call was made to each member who could not attend the meeting. This is a good example of what can be done when a third party plan does not meet our Principles of Acceptability.

The majority of third party dental plans in Indiana (and there are approximately 300,000 or more Indiana citizens covered by such plans) operate in accord with the I.D.A. Principles of Acceptability. Many health insurance company representatives have told us our principles are reasonable, realistic and efficient. When observed and applied by all concerned (i.e., dentist, patient and third party), there are fewer problems and the potential for real success. Experience and good judgment indicates this can be the same with the International Harvester-U.A.W.-Aetna Plan. We urge all I.D.A. members to cooperate by following our proven Principles of Acceptability.

Sincerely,

/s/ William G. Schmidt
WILLIAM G. SCHMIDT, D.D.S.
Chairman, Council on
Dental Care Programs

WGS: lm

cc: Dr. William G. Downes, Dental Administrator
Aetna Life Insurance Company

Mr. Burnosky, Associate Actuary Aetna Life Insurance Company
Mr. Worthington, Assistant Secretary Aetna Life Insurance Company
Mr. Rake, Field Representative, Health Insurance Council
Mr. D. A. C. Hill, International Harvester Manager of Industrial Relations, Indianapolis
Mr. W. F. Fentz, International Harvester Supervisor of Insurance and Pensions, Indianapolis
Mr. William F. Fitts, Assistant Director United Auto Workers International Harvester Representative, Detroit
Mr. Gene Kascaiss, Jr., United Auto Workers International Harvester Representative, Indianapolis
Mr. Owen C. Hammons, United Auto Workers International Harvester Representative, Louisville
Dr. Diefenbach, Secretary Council Dental Care Programs, American Dental Association
Mr. Drummey, Director of Group Insurance, Hartford, Conn., director of group insurance research, Conn. General Life Insurance Company
Dr. Kelly, President, Ohio Dental Association
Mr. Meckstroth, Executive Director, Ohio Dental Association
Mr. James Bowser, International Harvester Supervisor of Insurance and Pensions, Fort Wayne
Mr. Lloyd Ramel, United Auto Workers International Harvester Representative, Fort Wayne

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 76-F]

both have plants whose plans are administered by Aetna. Aetna's approach is to "stonewall" the I.D.A. That is, if radiographs are not submitted then Aetna is either refusing to pay the patient anything or reimburse them on a much lesser amount. Another problem is that oral surgeons are sending in preoperative radiographs post-operatively. This has caused a great deal of confusion among the general membership.

Dr. Long also reported that Chrysler had posted a list of nine Indianapolis dentists who would cooperate and send radiographs. Dr. Long tried to obtain the list, but it had been replaced with a bulletin indicating the shop steward would help obtain the name of a dentist who would cooperate with the Aetna requirements.

In conclusion, Dr. Long indicated that he was receiving several calls from dentists each day asking what could be done to resolve their problems. *He noted, from his conversations with members, that if the continued support for the "Indiana Plan" is to be forthcoming, then the Association must show members a solution to the impasse that is being initiated.* He also added in his opinion, there is a growing number of dentists sending in radiographs in the Indianapolis area.

New Castle

Dr. Sherman said he had contacted every dentist in the New Castle area and asked them for their comments regarding specific problems. The major problem had been with Aetna concerning their continued stonewall approach regarding radiographs. He noted

that crown/brige cases were being OK'd by Connecticut General, Equitable and Teamsters without the submission of radiographs; however, in every case involving similar work Aetna was not paying anything or reimbursing the patient on a much lesser amount.

New Albany

Reporting for the New Albany area was Dr. John Huff. It was noted that a great many people work in the Louisville area, but live in Indiana. In addition, it is easy for a patient to change dentists and be treated in the Kentucky area, because those dentists will send radiographs to Aetna. Dr. Huff said many Indiana dentists in the New Albany area had lost entire families to Kentucky dentists. Dr. Huff noted that Indiana patients are being directed to Kentucky to receive their dental treatment by U.A.W. union stewards and Aetna. Dr. Huff indicated he had a list of Indiana dentists in his area who had lost patients along with the approximate dollar amount that had been taken out of their practices. Dr. Huff said he would forward this information to Mr. Kirages for his follow up.

It was noted that Aetna's dental consultant in the New Albany area was not Indiana licensed. Mr. Kirages indicated that if he was diagnosing and changing treatment plans suggested by a dentists in Indiana then Aetna's consultant could be considered as practicing dentistry in Indiana and subject to violation of the Indiana Dental Practice Act. Mr. Kirages emphasized such statements must be documented. The Council asked Mr. Kirages to investigate and find out if Aetna's Kentucky consultant is in violation of the Indiana Practice Act when he receives the information from Dr. Huff.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 89-E-F]

Indianapolis District—Dr. Solomon reported on the activities of Dr. Finkbiner. He noted that x-rays are being taken at the Allison Diesel Plant in the Indianapolis area. It appears that Dr. Finkbiner also accepts as payment in full the amount the insurance will pay. Dr. Solomon raised the question of whether or not this type of action was legal.

Dr. Solomon reported to the Council that he had met with Mr. Dallas Sells of the U.A.W. to discuss the situation that now exists at the Allison plant. Dr. Solomon also indicated that this present situation might give rise to the creation of a sponsored union clinic. In his discussions with Mr. Sells, he believed that Mr. Sells did not feel the I.D.A. had really tried to have any mutual meeting ground in order to correct the problem. Dr. Solomon also reported that he might get a copy of the proposal for the union clinic; however, todate he had not received anything. In addition, Dr. Solomon believed that another reason a union dental clinic is being talked about is because dentists will not accept assignment.

Dr. Gossweiler commented on a meeting that had taken place between representatives of the Metropolitan Insurance Company and the Indianapolis District Dental Society Dr. Gossweiler indicated that the purpose of the meeting as far as Metropolitan was concerned was to convince Indianapolis District Dental Society to submit x-rays. The Metropolitan representatives were referred to Dr. Schmidt for any future contact regarding the submission of x-rays.

In an effort to resolve certain problems Mr. Sells had indicated he was interested in a future meeting with

the I.D.D.S. representatives of the Council. After considerable discussion, it was the consensus of the Council that Dr. Solomon should pursue such a joint meeting. Dr. Solomon indicated he would do so and at the same time keep the Central Office informed.

Isaac Knapp—Dr. Dumas reported that the situation has remained fairly stable in the Isaac Knapp area. He did note, however, that Aetna's dental consultant was doing more spot checking.

North Central—Dr. Douglas noted that at the present time the situation was very quiet and, with only a few exceptions, most carriers were not taking a strong stand as for the submission of x-rays.

Northwest—Dr. Corns reported that about the only problem todate has been with the Aetna Insurance Company. He did note that with the steel industry receiving dental insurance as of August 1, 1975 the Northwest Component has organized a contact program to better educate its membership regarding the Indiana Plan.

South Central—Dr. Sawin indicated that primarily most of the problems originate in the New Albany area because of its close proximity to the Louisville area.

Southeastern—No representative available

Wabash Valley—Dr. Ricci reviewed a handout that was initiated by the union. He noted that this type of material was appearing monthly in the union newspaper. Dr. Ricci also said it was his feeling that we are losing support for the Indiana Plan, because the Association is unable to show the membership what it is doing to resolve the x-ray issue. He further noted that some men feel it is not being resolved and therefore are beginning to send x-rays.

West Central—Dr. Fontaine reported that the West Central Component was very unified. He also noted that as a result of the contact made by the West Central Component, the Travelers Insurance Company had changed its position and was now paying claims without x-rays being submitted. Dr. Fontaine emphasized that each component society must organize and become involved in order to promote the Indiana Plan to its membership.

Western Indiana—Dr. Thomas Layman reported that problems were evident in the Terre Haute area in that Metropolitan was not paying claims unless radiographs were submitted. Dr. Layman also reported that some dentists in the Western Component were submitting x-rays.

EVALUATION OF REVISED A.D.A. CLAIM FORM

Mr. Quinn reviewed the revised dental claim form that was recently approved by the Health Insurance Association of America, Delta Dental Plans and the A.D.A. Council on Dental Care Programs. Mr. Quinn noted that the form was similar to the 1971 form. However, he pointed out some major differences which are as follows:

1. The 1971 form contains the following statement. "I hereby Authorize Payment Directly To The Below Named Dentist Of The Group Insurance Benefits Otherwise Payable To Me. But Not To Exceed The Charges Shown. I Understand That I Am Financially Responsible For Any Charges Not Covered By This Authorization."

   The 1975 form *does not* contain the last two sentences which read as follows. "But Not

To Exceed The Charges Shown. I Understand That I Am Financially Responsible For Any Charges Not Covered By This Authorization."

2. The other major change is that the statement on the 1971 form which reads as follows. "I Hereby Certify That The Services Listed Above Will Be —— Have Been —— Performed" now reads "I Hereby Certify That The Procedures As Indicated By Date Have Been Completed."

After a great deal of discussion the following motion was passed by the Council.

Resolved, that the I.D.A. Council on Dental Care Programs investigate further the newly revised 1975 A.D.A. claim form to insure that all aspects of the form do not in any way cause problems for the attending dentist who would be signing such a form.

PASSED

The major area of concern with the form was that the statement regarding the patient's financial responsibility was left off.

In addition, the Council also voiced concern that insurance companies are given the prerogative to change different parts of the form as they feel necessary. The Council believed this defeated the purpose of a uniform claim form.

REVIEW REQUEST FOR DENTAL CONSULTANTS

The Council reviewed the request of Dental Insurance Consultants, Inc. As per Dr. Louis A. Saporito's July 3, 1975 letter D.I.C. is requesting that the Asso-

ciation recommend a list of individuals who might serve as the state coordinator for D.I.C. in Indiana.

After a great deal of discussion and a review of the State Coordinator Agreement *it was the consensus of the Council that Dr. Schmidt should contact Dr. Lloyd Phillips*

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 151-A-B]

Current Update prepared for the
Odontological Society of South Western Pennsylvania,
February 28, 1976

by Dr. W. Kelley Carr

What's Happening In Indiana?

1. First what about the current status of the Indiana plan? In three areas of the state the plan is having problems. These are all urban areas.

A) In Indianapolis area dentists suffer from 1) an ultra large society with inadequate peer pressure (which we utilize well in the smaller more cohesive societies to help maintain and develop support for Indiana Plan.

2) Indianapolis has excess of dental manpower. The dentist population ratio is 1:1300 (and this includes the poor area of Indianapolis.) Many of the dentists were already economically coerced by inadequate dental demand and then suddenly a large percent of their practice falls into the hands of one third party—those men are just not well enough organized and financially solvent to resist the intrusions. *There are many supporters* of the Indiana Plan in Indianapolis. I have seen card polls where handwritten messages such as—"If our society submits x-ray I quit."

B) In the Gary area of Northwest Indiana. 1) This is a mix of urban and rural areas. It has strong nests of support and disorganization both. The existence of the strong support areas has resulted in major modification of private insurance plans operating in the area. If x-rays are submitted, they go only to a dentist practicing in the component society area, a local consultant. I am told several of the insurance companies in the area operate without requesting radiographs. 2) Card polls—where all cards are not returned are not overly conclusive. It appears that over 50% of the dentists do not submit radiographs. 3) Illinois dentists submit radiographs and some patients travel to Illinois, have x-rays taken and return to family dentist for care—those *patients* who are forced to do this by the third party *are mad at the third parties*—not the dentists—since they know many other companies in Indiana work without requiring the dentist to submit radiographs.

C) Jeffersonville area—1) This is directly across the river from Louisville and in Jeffersonville dentists who do not submit radiographs are hurt by the willingness of fellow dentists in urban Louisville who will intentionally do this to gain a patient. *Why should cooperation break down at the waters edge?*

Now what about the good news?

The smaller urban areas and rural areas *are doing quite well.* (The majority of our dentists). They appear to be much stronger as our dentists understand the necessity to resist intrusions in the dentist to patient relationship. In the Lafayette area there are

only two dentists out of 80-86 dentists who are known to submit radiographs. In the Anderson area one dentist out of 93 will submit radiographs. The Fort Wayne area is just as strong. In the North Central area (South Bend) there are over 200 dentists. In that area their trustee (who has always supported the Indiana Plan) was replaced in an election contest this spring because he didn't support the plan vigorously enough! *That area is adamantly opposed to any changing of the Indiana Plan in negotiations with the Insurance Commissioner.*

Overall View.

The dentists in our state are influenced by what they see happening when they are united (and I might add as the result of education—not coercion). For example in my area we only have one company which occasionally requests radiographs—*which they don't get.* Two weeks ago one general dentist told me it has been three years since he has had a request for a radiograph! It has been over two years since I have had a request. The plain facts are the insurance companies can use other methods of controlling their costs than requesting radiographs. Yes, the Indiana Plan is alive, working and in seven areas where unity is well developed it is much stronger than it was two years ago! It has been effective throughout our area in preserving the doctor patient relationship.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 186-A-C]

February 13, 1976

MEMO

To: Charlene Hillman and Barbara Rafferty

From: Gale E. Coons, Executive Director

The enclosed paper by Dr. K. Carr will give you some additional insight regarding the IDA's position on lots of things relative to group-funded programs in particular.

Remember Dr. Carr is one of the leaders.

Sincerely,

Gale E. Coons
Executive Director

GEC/mw
Enclosure

REMARKS FOR BARKLEY, KENTUCKY BEFORE QUESTIONS AND ANSWERS

Unique position—Your problems are very similar to ours in Indiana some 10 to 12 years ago.

1. It was the non super large urban and non educationally dominated areas of our state which developed the Indiana Plan to protect our patients and private practice.
2. We were able to just barely gain control of our House of Delegates over a ['] year period. We did this by encouraging excellent articulate dedicated men to act as delegates and by recruiting friends who thought like we to become delegates in the super large urban areas. We did it for the profession and the public not for personal gain.
3. About half of our delegate votes are in two very large urban dental societies. I believe your Louisville-Bowling Green combination is probably similar. This makes it difficult to win votes on resolutions—but we did it. Our effort was made easier by using two goals for making decisions: 1) Did it encourage quality dentistry? 2) Did it serve the public?
4. Leadership in our largest society, Indianapolis, and also in the Cleveland area of Ohio is decidedly older—with less personally at stake (except for prestige) than with the smaller societies. I believe the younger men need to participate in the leadership activities now and deserve more say so about their working conditions of the future, but this has been hard for some of the older men to

understand and accept. We have crossed this barrier in Indiana—all our leadership is serious about the issues—nobody anymore really wants a chair for prestige only—the responsibilities are known and enormous.

5. Our out caucus gained domination of the urban areas at a time prior to much dental insurance—and this made it easier for us. Today we still have problems in the 3 urban areas:
   a) Jeffersonville across from Louisville. Many of the patients go to Kentucky dentists who submit x-rays
   b) Indianapolis—too many dentists there
   c) Northwestern Indiana—Some problems but not those of Indianapolis and Jeffersonville.
6. Indiana is very well organized in many of the out areas. For example in my component of 86 dentists, only two are known to submit radiographs. This unity is not by accident.
7. In the out areas trail by fire has strengthened our resolve to resist intrusion in dental-patient relationships and the financial conduct of our practices (i.e. we don't pre file fees, we don't accept assignment of benefits, we don't sign participating dentist agreements, and we don't submit radiographs).
8. We do utilize the Indiana Dental Association Standard Claim form (not the ADA form) we do exert peer pressure without throwing members out of our society or making special

assessments. We do work to influence which company gains an insurance contract in our towns, we do work to protect our patients benefits, we do work to minimize administrative costs associated with third parties, we do continue to look for alternatives for we know things change.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 214-B-C]

JAMES E. DUMAS, D.D.S. DAVID G. BOJRAB, D.D.S.

Practice Limited to Oral Surgery

3030 LAKE AVENUE
FORT WAYNE, INDIANA 46805
TELEPHONE 422-7171

February 2, 1973

James D. Frey, D.D.S.
President Elect
Isaac Knapp Dental Society
3501 S. Harrison Street
Ft. Wayne, Indiana 46807

Dear Dr. Frey:

We in the Fort Wayne Area, practicing oral surgery, have to this date upheld and abided by the Principles of Acceptability of the Indiana Dental Association regarding submission of radiographs to third party insurance carriers.

We have lately become aware of the fact that a fellow oral surgeon, namely Dr. Donald Lloyd, has on numerous occasions submitted x-rays to third parties, and has openly admitted this to members of the Dental Society.

We, the undersigned, will not sit idly by and let one oral surgeon control the majority of oral surgery performed on Harvester employees and their families, especially when he is doing this by direct violation of the Principles of Acceptibility of our Society.

We are petitioning the Ethics and Censorship Committee of the Dental Society to meet with Dr. Lloyd regarding his undermining of the Principles of Acceptibility of the Indiana Dental Association.

If Dr. Lloyd continues to submit x-rays to third party insurance carriers, we as oral surgeons may have to alter our present direction regarding submission of films.

Sincerely,

/s/ James E. Dumas, D.D.S.

/s/ David G. Bojrab, D.D.S.

/s/ Charles T. Frissell, D.D.S.

/s/ Richard J. Miller, D.D.S.

/s/ Thomas V. Doty, D.D.S.

/s/ David A. Illegible, D.D.S.

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OPPOSITION

BRIEF

Supreme Court, U.S.
FILED
JUL 15 1985
ALEXANDER L. STEVAS,
CLERK

No. 84-1809

In The
Supreme Court of the United States
October Term, 1984

FEDERAL TRADE COMMISSION,
Petitioner,

V.

INDIANA FEDERATION OF DENTISTS
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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INDIANA FEDERATION OF DENTISTS

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

STATEMENT OF THE CASE

The instant case evolved as a result of the growth of group dental health care reimbursement plans and the resultant interaction of dental plan administration with dentists and their insured patients.

Insurance companies underwriting such dental plans believed that success in the market place mandated con-

trol over dental costs and consequently, insurers attempted to devise methods to control dental costs (App. 2a).[1]

The alleged cost controlling mechanisms utilized by insurers were "predetermination of claims" (predetermination) and "least expense adequate treatment" (App. 2a). Predetermination is a plan allowing the dentist to prefile with the insurer's claim office the proposed course of treatment for the covered patient so that a pre-estimate of the benefits payable can be effected by the insurer (App. 2a). The "least expensive adequate treatment" is a plan in which an insurer will invoke benefits for the least expensive, but supposedly adequate dental treatment procedure as determined by the insurance claim office (App. 2a). Least expensive adequate treatment is invoked by an insurance company based upon review of requested x-rays and dental claim forms (App. 3a).

Since the inception of group dental plans, it has been standard practice for insurers to automatically require dentists to submit radiographs (x-rays) and patient claim forms for review by the insurers' claims personnel (App. 3a). X-rays were routinely requested (App. 3a) despite the fact that ninety percent (90%) of all claims were paid without the need of an x-ray (Rap. 1-2). If a dental claim was approved, normally by a non-licensed lay examiner, the claim would be paid by the insurer (App. 3a). If approval was questioned by the lay examiner, the claim form and x-rays were supposedly submitted to a licensed

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1 App: Petitioner's Appendix
Rap: Respondent's Appendix
Pet. Br.: Petitioner's Brief

dental consultant employed by the insurance carrier who would determine whether to pay the claim, deny the claim, or pay for only the least expensive adequate treatment as determined by the dental consultant (App. 3a).

Because group dental plans interacted with the dental profession, the American Dental Association formed a council on dental care programs (CDCP) to study the implementation of prepaid dental programs throughout the country.

Sometime before 1970, the Indiana Dental Association (IDA) established a council on dental care programs to study the impact of third party dental insurance plans on the dental profession (Rap. 2-3). Eventually, a manual on group funded dental care programs was produced and distributed by the IDA (Rap. 4). The IDA manual familiarized dentists involved with third party insurers regarding IDA's perception of how the dental plans should work consistent with Indiana law and proper dental diagnosis and treatment. The "principles of acceptability" as adopted by the IDA, were included in a manual on group funded programs and provided guidelines and procedures for dealing with group funded dental programs. Although the IDA's principles of acceptability delineated a number of procedures and guidelines, the most controversial provision provided as follows:

> 5. Dental radiographs are a part of the dentist's legal health records. They are available for valid review by a qualified representative(s) of your insurance company in this office. Radiographs will not be submitted to third parties for their use in determination of benefits (e.g., least expensive adequate treatment) because a determination of an adequate treatment plan can only be made after a knowledge of the

following: (a) complete patient evaluation; (b) radiographs; (c) additional diagnostic procedures as required. (App. 6a).

During the time period of 1971 until 1978 Aetna received approximately fifty percent (50%) of requested x-rays from IDA dentists (Rap. 5). Before August of 1976 a movement began among some Indiana dentists to form a dental organization, separate and apart from the IDA. In August of 1976, the Indiana Federation of Dentists (IFD) was formed. The IFD is an unincorporated association of Indiana dentists affiliated with the American Federation of Physicians and Dentists. IFD's membership is located in and around the three (3) localities of its chapters: Madison County, Daleville, and Middleton (Chapter 1), Tippecanoe, Clinton, White and Carrol Counties (Chapter 2), and Allen County (Chapter 3). As of 1979, IFD had approximately eighty-four (84) present members and eight (8) former members (App. 8a).

On April 24, 1977, the IFD adopted a "work rule" which essentially embodied the organization's position regarding proper dental diagnosis and corresponding dental treatment. The IFD "work rule" read as follows:

> Proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids with a history and with all clinical findings. No one facet of this process is now, or ever has been, recognized by the profession as a substitute for the complete process. To represent otherwise would subject the patient to substandard care. The patient's dentist, therefore, has a *moral* and *legal* responsibility to not allow a determination of his patient's condition to be made for any purpose, without the benefit of a complete examination which takes into account all of the elements described. (App. 9a). (Emphasis supplied)

The Federal Trade Commission (Commission) on October 18, 1978 interjected itself into the x-ray dispute by filing a complaint against the Indiana Federation of Dentists. The Complaint asserted, *inter alia,* that IFD had engaged in unfair methods of competition and unfair acts and practices in violation of Section 5 of the Federal Trade Commission Act. The Initial Decision was filed on March 25, 1980. The Initial Decision concluded that IFD had conspired with the IDA to continue a concerted refusal to submit dental radiographs (x-rays) to insurance companies underwriting group dental insurance programs. Said concerted refusal by IFD was determined to be a *per se* unreasonable restraint of trade (App. 276a).

An appeal from the Initial Decision and resultant Order was effected by Respondent IFD and oral argument was presented to the Commission on September 18, 1980. Thereafter, on February 17, 1983, some two (2) years and five (5) months after oral argument, the Commission filed its decision and accompanying Order (App. 113a). The Commission decided that the Initial Decision's *per se* analysis was inappropriate and that a rule of reason analysis must be employed. The Commission summarily concluded that under a rule of reason analysis, concerted activity by competitors (IFD) resulted in reducing or eliminating competition among dentists as to their policy of dealing with third party payer insurance companies (App. 85a). This essential finding by the Commission assumed, *without record evidence,* that all IFD members competed against one another in their handling of third party dental insurance payment plans, and that concerted activity by competitors (IFD) reduced or eliminated this unproven element of competition. On October 11, 1984, in a well

reasoned opinion the Seventh Circuit Court of Appeals concluded that:

> . . . under a rule of reason analysis, the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market. (App. 2a).

REASONS FOR DENYING THE WRIT

The Commission's entire argument is whether the Court of Appeals applied the proper standard of review in vacating the order of the Federal Trade Commission. The Commission candidly recognizes that this Court has placed responsibility for determining substantial evidence questions in the Court of Appeals, and "will intervene only in what ought to be the rare instance when the [substantial evidence] standard appears to have been misapprehended or grossly misapplied." *American Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490, 523 (1981).

The Court of Appeals, cognizant of its role in determining substantial evidence stated:

> In our review of the Commission's Order we are guided by the Congressional Language of 15 U.S.C. §45(c) (1982), that "[t]he findings of the Commission as to the facts, if supported by evidence, shall be conclusive." According to the settled law in this circuit, the Commission "may draw reasonable inferences from the record." *Spiegel, Inc. v. F.T.C.*, 540 F. 2d 287, 293 (7th Cir. 1976) (citing *Consolo v. Federal Maritime Commission*, 383 U.S. 607, 620 (1966)). (App. 20a).

The Commission's finding that IFD engaged in unfair methods of competition was based on Sherman Act principles (App. 97a, n. 24). As such, review of the Commission's order must be guided by legal principles of federal antitrust law. Since the Commission employed a rule of reason analysis in concluding that IFD had engaged in anticompetitive acts, the Commission carried the burden of showing as an essential element of illegality, some anticompetitive market effect. The requirement that a plaintiff *prove* anticompetitive effect in a relevant market is well established in the Seventh Circuit. *Lektro Vend. Corp. v. Vendo Co.*, 660 F. 2d 255, 268 (7th Cir. 1981); *Contractor Utility Sales Co. v. Certain-Teed Products Corp.*, 638 F. 2d 1061, 1078 (7th Cir. 1981); *Juneau Square Corp. v. First Wisconsin National Bank*, 624 F. 2d 798, 810-811 (7th Cir.), Cert. denied 449 U.S. 1013 (1980); *Havaco of America Ltd. v. Shell Oil Co.*, 626 F. 2d 549, 554 (7th Cir., 1980). This Court has clearly provided that "the inquiry mandated by the rule of reason is whether the challenged agreement is one that promotes competition or one that suppresses competition." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 691. The Court of Appeals, in applying the substantial evidence standard, concluded that the Commission failed to establish that the conduct of IFD had an anticompetitive effect in a relevant market. Thus, unless the Court of Appeals misapprehended, or grossly misapplied the substantial evidence test, the Commission's petition must be denied. In support of this contention, the Commission merely restates the theories proposed to the Court of Appeals.

As contended by the IFD from the onset of this case (Rap. 6-7) the Commission failed to establish any anticom-

petitive effect in a relevant market. This is evidenced by the Commission's essential, but unsupported finding in its final order:

> Such concerted activity by competitors resulted in reducing or eliminating competition among dentists as to their policy of dealing with third party payers. Patients who were covered by dental plans providing for cost containment programs such as those here found it difficult to purchase care from dentists who would satisfy the terms of their coverage. In the absence of such concerted behavior, individual dentists would have been subject to market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third party insurers. By colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate. Consequently, the dentist-insurer relationship was determined by economic coercion, not by market competition. The final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs. (App. 85a).

This finding by the Commission assumed, without record evidence, that all IFD members competed against one another in their handling of third party dental insurance plans, and that this "concerted activity by competitors" somehow reduced or eliminated this unproven element of competition. An example of a conclusory proposition advanced by the Commission is contained in the Commission's Petition for Writ of Certiorari, page 10, wherein the Commission states:

> [F]urnishing claims information to insurers is thus an integral part of the service offered by the dentist as an independent competing entrepreneur, . . . and many consumers will choose a dentist who cooperates with insurers in processing claims in preference to one who does not.

This unsupported assertion assumes that patients will choose claims processing convenience over quality dental care. Similar unsupported theories compromised the majority of the Commission's case against IFD. The Commission, recognizing an evidentiary deficiency, now contends that IFD has conceded (in prior appellate briefs) that competition was an element among IFD dentists in dealing with dental insurers. Apparently, in an effort to evidence an unproven aspect of competition, the Commission is reduced to quoting paragraphs from briefs prepared by IFD in response to a confusing and ambiguous Commission complaint (App. 122-126a). In a further effort to support its theory, the Commission offers documents supposedly evidencing the fact that IDA dental patients were shifting to complying dentists in nearby Louisville, Kentucky (App. 300a). However, the Commission's own trial exhibit demonstrated that Indiana dental patients were being directed to Kentucky by *UAW union stewards* and the *Aetna Insurance Company* (App. 300a).

Based on record deficiencies, the Court of Appeals correctly determined that the Commission failed to establish that IFD members competed against one another in their handling of third party payment plans. Moreover, the Commission completely failed to establish the relevant market upon which the anticompetitive effect ostensibly impacted. The Commission's sole attempt at market definition was contained in a single footnote in the Commission's Final Order:

> As in any rule of reason case, attention must be paid to market definition in order to assess competitive effects. No elaborate analysis is required here, since the record shows that under IDA's leadership, the conspiracy spanned many, if not most localities in Indiana. Under the leadership of IFD, it continued to be strong in the local areas covered by that organization's three (3) chapters. The record shows no competition from out-of-state dentists, except in two localities near Louisville, Kentucky. (App. 85a).

The Commission fails to address this obvious absence of market definition, an essential prerequisite to antitrust liability. As the Court of Appeals noted:

> An *examination* of the effect on competition is not sufficient, there must be an actual *showing* that the alleged proscribed conduct has an anticompetitive effect in a *relevant market*. (App. 35a). (Emphasis supplied)

Alternately, the Commission argues that the Court of Appeals somehow erred by referring to the "dentists adherence to a legal, moral, and ethical policy of quality dental care." Evidently the Court of Appeals, so the argument goes, was expressing its "evident disapproval" of this Court's decision in *National Society of Professional Engineers v. United States*, 435 U.S. 679, and creating a "de facto" exemption for professionals under the guise of the substantial evidence test (Pet. Br. 8). This bald assertion ignores the plain holding of the Court of Appeals. Cognizant of the application of antitrust laws to the professions[2], the Court of Appeals concisely stated the issue to be decided:

---

2 An excellent opinion regarding the application of the rule of reason to health care professionals was rendered by the Seventh Circuit Court of Appeals in *Wilk v. American Medical Ass'n.*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, — U.S. —, 104 S.Ct. 2398, 81 L.Ed.2d 355 (1984).

> The issue squarely before this Court is whether the collective refusal of the IFD member dentists to comply with the group dental hea'th care insurers directive to submit copies of a patient's dental x-rays along with the patient's insurance claim form violates the Federal Trade Commission Act, Section 5. (App. 20a).

The Court of Appeals clearly delineated the holding of the case at bar:

> Thus, we hold that, under a rule of reason analysis, the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market, in violation of the Federal Trade Commission Act, Section 5. (App. 45a).

The Commission itself has argued that the work rule of the IFD operated as a concerted refusal to automatically send x-rays to insurers (Pet. Br. 4). This very work rule refers to the legal, moral, and ethical obligations of the IFD dentists (App. 9a). It can come as little surprise to the Commission that the Court of Appeals referred to these matters in deciding whether IFD's conduct harmed competition among dentists in their policy of dealing with group dental health care insurers. The instant decision clearly delineates that professional motives do not excuse anticompetitive conduct (App. 33a-34a). This decision holds that the Commission failed to establish anticompetitive conduct in a relevant market. Even the concurring opinion issued by Senior Circuit Court Judge Fairchild (upon which the Commission ostensibly relies) clearly states that no evidence was developed or the validity of an assumption that a dentist's policy of refusal or cooperation has any significance in competition among dentists, and that the Commission, in any event, failed to analyze the

proposition (App. 49a). The presence of a possible economic motive does not relieve the Commission of its burden of proving anticompetitive effect in a relevant market.

The Commission requests that this Court intervene and again reweigh the substantiality of the evidence, an undertaking this Court should decline absent a gross misapplication of the substantial evidence test. *American Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490. The specious nature of the Commission's request is evidenced by the refusal of the Solicitor General to file a Petition for Certiorari on behalf of the Commission. (Pet.Br. p1, n1).

CONCLUSION

The Commission has failed to establish that the Court of Appeals misapprehended or grossly misapplied the substantial evidence standard. The Commission failed to demonstrate that the instant decision is in conflict with another federal court of appeals decision; nor, does the instant decision decide a novel question which has not been addressed by a prior decision of this Court.

Consequently, the Petition for Writ of Certiorari should be denied.

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No. 84-1809

In The
Supreme Court of the United States
October Term, 1984

FEDERAL TRADE COMMISSION,
Petitioner,
V.
INDIANA FEDERATION OF DENTISTS,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

APPENDIX TO RESPONDENT'S BRIEF IN OPPOSITION

Of the total number of claims that are paid, do you have some figures you could enlighten the court on? Say, percentagewise, how many of the total volume of claims in Indiana are paid that way?

A. Well, at this time, of the claim submission, it's over ninety percent of the claim submissions are paid that way.

Q. Without need of an X-ray.

A. Yes.

JUDGE TEETOR: Is that in dollars or people?

THE WITNESS: That is in terms of the number of claim transactions, the number of claim submissions.

BY MR. FOWLER:

Q. How does that compare in dollars?

A. Well, in terms of dollars, it's a smaller percentage than ninety percent, because it includes the routine and frequent routine services, such as amalgam fillings and cleanings, prophylaxis and X-rays.

(p. 2386) Q. Were you ever a member of the Board of Delegates of the IDA?

A. The House of Delegates of the IDA?

Q. House of Delegates.

A. No, I was never a member of the House of Delegates.

Q. In your membership with the IDA, have you had any duties with regard to the advent of third-party dental care coverage?

A. Yes, I certainly have. They have been many and varied.

Do you want me to elaborate?

Q. Yes, if you will.

A. Prior to the advent of third-party intervention in the profession of dentistry in the state of Indiana, we were well aware of its coming; and so, the Indiana Dental Association formed the Council on Dental Care Programs to primarily study what the impact of what third-party involvement would be to the profession. We felt that being its nominal leaders that we had the responsibility to acquainting ourselves with this and consequently acquainting the members with just really what was involved in third-party dentistry and what effect it would have on them and how we would recommend ways to cope with the problems created by this intervention.

Q. What years was that, if you can recall?

(p. 2387) A. Well, it went back—Are you talking about my participation?

Q. Yes.

A. My participation probably went back to the early seventies or maybe late sixties. Directly and indirectly, I was involved, I think, from the very beginning, mainly because of my position on the Board of Trustees. Any activities that the councils and committees of the Indiana Dental Association, the way it was constituted—I mean the Indiana Dental Association was constituted—was that the Board of Trustees was the interim policymaking board that functioned between the meetings of the House of Delegates, which were only annual unless special meetings were called. So any of the work that was done by these councils or committees, and the Council on Dental Care Programs was only one of them, were brought to the Board

of Trustees and explained thoroughly to us. A lot of times, we had recommended action to take on those reports.

And so, either directly or indirectly, I was involved with this procedure of investigating the impact of third-party dentistry on our profession from back in the early sixties.

JUDGE TEETOR: You say early sixties?

THE WITNESS: That's true. That's correct.

• • •

A. The general purpose articulated, and what I personally felt about it, was that we felt in our roles as leaders of the Indiana Dental Association that it was our responsibility to investigate this activity and that we should familiarize ourself with it and then, more or less, summarize them in some principles whereby each individual could readily get a handle on this; because, in truth, there were untold manhours involved in understanding insurance terms, really. And I can remember the first time I became familiar with some of the insurance terms that were being used, I had no idea what they meant. And going back insofar as to just get nomenclature outlined became a problem to me. And so, we tried to condense these to a point where we could give direction to our members, as we felt it was our responsibity being in leadership positions.

Q. So you would define the dental insurance nomenclature to your members through the principles of acceptability. Is that my understanding?

A. No, not precisely that, although we did come out with some nomenclature—Well, it was the later days of the manual that we finally came out with nomenclature.

Q. What do you mean by the manual?

A. All right, we developed a manual on group funded dental care programs, I believe it was.

I am asking, during that time period, what was the approximate rate of submission. If it varied, I would like to have the variations.

JUDGE TEETOR: The rate of submission?

MS. GEE: Of X-rays from dentists in Indiana.

JUDGE TEETOR: Okay.

A. I asked for a survey, a spot check at one point in time during that period. And I learned on the basis of this small sample that we were getting X-rays about fifty percent of the time we were asking for them.

Q. Approximately when was that spot survey, if you recall.

MR. GRAHAM: We are going to object, your Honor, to that evidence. There's no foundation for where this spot survey has taken place.

JUDGE TEETOR: You may continue to answer.

Q. Approximately when?

A. It was—And I can't remember very exactly here, but it was somewhere in the vicinity of 1975 or '76.

Q. Do you know the approximate rate of X-ray submission under dental plans, in other parts of the country where Aetna has dental plans outside of Indiana?

• • •

the alleged anti-competitive factors of respondent are not indicated in the Initial Decision. Without a delineation of these "alleged" anti-competitive factors of respondent no worthwhile balancing can occur. Indeed, the Court of Appeals, Second Circuit, in *C.B.S. v. A.S.C.A.P.* Docket No. 75-7600 (No. 120, 4/3/80), held that under the Rule of Reason analysis, the complained of action must be shown to be *anti-competitive* before any antitrust violation is made out. The Court in *C.B.S.* dismissed an antitrust suit because no showing of *anti-competitive* effect was demonstrated. Clearly, no showing of anti-competitive effect of respondent's conduct has been established in the Initial Decision, and thus any references to such "alleged" anti-competitive factors are *unsupported* (e.g. Initial Decision paragraph 125). Further, the Law Judge concludes that respondent "shut off" insurer's access to X-rays and thus organized an unlawful economic squeeze play. (Initial Decision, paragraph 122) Footnote 337 of the Initial Decision (page 89) defines the allegedly unlawful shut off:

337 "Shut off" is not too strong a term under the circumstances here. It is true that most dentists have typically expressed their willingness to let insurers' "qualified" experts come to their (the dentists') offices to look at X-rays and other diagnostic aids, (CX 99W). However, there is abundant testimony in this record that that is an empty offer because it *is not economically feasible* for the insurers to send experts around to each dentist's office (Tr 341-42, 924-25, 978, 1121, 1232, 1383-84,)

REPLY BRIEF

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No. 84-1809

In the Supreme Court of the United States

OCTOBER TERM, 1984

Federal Trade Commission, Petitioner

v.

INDIANA FEDERATION OF DENTISTS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

REPLY BRIEF FOR THE FEDERAL TRADE COMMISSION

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In the Supreme Court of the United States

OCTOBER TERM, 1984

No. 84-1809

FEDERAL TRADE COMMISSION, PETITIONER

v.

INDIANA FEDERATION OF DENTISTS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

REPLY BRIEF FOR THE FEDERAL TRADE COMMISSION

Unable to defend the court of appeals' rationale for vacating the Commission's order, the Indiana Federation of Dentists (IFD) in its Brief in Opposition advances an argument not adopted by the court below. Neither this argument, nor those given by the court of appeals, however, warrants exoneration of the type of anticompetitive conduct by health care professionals involved in this case.

1. IFD does not contest the substantial documentary evidence cited in the petition and appendix (Pet. 10-11, App. 289a-314a) demonstrating the competitive significance of dentists'' submission of dental x-rays to insurers, *e.g.*, the patient shifts that would result from the willingness of some dentists to submit x-rays to facilitate claims payments to customers.[1] Similarly, 1IFD does not (and cannot) deny the concessions made in its briefs to the Commission that dentists who submit x-rays to insurers will be favored by some

[1] IFD's only rejoinder is to observe that one of the documents cited by the Commission demonstrates that an insurance company and union directed patients to dentists who would submit x-rays (IFD Br. 9). Like the record evidence IFD ignores, this document also confirms that patients switched dentists because of their claims payment policies, which the document suggests was a matter of competitive concern to participants in the boycott (App. 299a-300a).

patients (Pet. 10).[2] In short, IFD does not seriously dispute the existence of substantial competition among dentists for patients based upon x-ray submission policies, which the court of appeals failed to recognize. IFD dentists restrained this competition through agreements to act uniformly to withhold dental x-rays and thereby restrict the dentists' output of a service (claims processing) that is significant to patients with dental insurance policies. See *NCAA* v. *Board of Regents of Univ. of Okla.*, 104 S.Ct. 2948, 2960 (1984).

2. Having declined to defend the central ground on which the court below purported to rest its decision, IFD claims instead that the Commission failed properly to establish the relevant market in which the dentists' anticompetitive boycott was perpetrated. However, despite apparent misgivings, the court below did not reverse the Commission on this ground (App. 35a-36a). Nor could market definition be a proper ground for reversal, because the record shows that the statewide Indiana Dental Association (IDA) and co-conspirator IFD wielded considerable market power over dental services in those localities affected by the conspiracy.[3]

Since the boycott originally involved almost the entire state during the IDA phase of the conspiracy and persisted in localities where IFD's three chapters operated, the Commission did not need to delineate with specificity the contours of each local market involved (App. 84a-85a & n.12). This Court has recognized that a showing of injury to competition, even in rule of reason cases, may not require establishment of a defendant's power in any precisely defined market. *NCAA* v. *Board of Regents of Univ. of Okla.*, 104 S.Ct. at 2965 & n.42.

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[2] While IFD claims these concessions are the product of "briefs prepared * * * in response to a confusing and ambiguous Commission complaint" (IFD Br. 9) it does not disavow them or suggest they misstate the truth.

[3] Co-conspirator IDA accounted for more than 85% of licensed Indiana dentists (App. 84a) and IFD has itself stated that its members included at least 66-69% of dentists practicing in the area covered by its Chapter I (Anderson) and at least 50-56% of dentists practicing in the area covered by its Chapter II (Lafayette)(IFD Appeal Brief to Commission at 24).

3. Finally, IFD seeks to justify the majority opinion's core determination that IFD was merely adhering to a "legal, moral, and ethical" policy to promote "quality dental care" by explaining that IFD's challenged work rule used these terms (IFD Br. 11). Plainly, however, by its more than 20 references to these phrases, the reviewing court did not purport to be merely quoting or paraphrasing IFD's work rule. Its repeated references embrace the validity of IFD's asserted motivations and dictated the outcome of its decision. The Commission had found that these asserted legal, moral, and ethical justifications had no record basis (App. 91a-92a, 100a-101a, 240a-241a). The reviewing court improperly failed even to consider the Commission's finding on this point.

Unless reversed by this Court, the Seventh Circuit's opinion will needlessly encourage other groups of health care professionals to engage in anticompetitive boycotts, camouflaged by claims that they reflect "legal, moral, and ethical" policies to promote "quality of care." Such a result will affect adversely efforts to contain health care costs--and consumers who ultimately pay health care bills.

CONCLUSION

For the foregoing reasons and the reasons stated in the petition, the writ of certiorari should be granted.

Respectfully submitted,

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JOINT

APPENDIX

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FEDERAL TRADE COMMISSION, PETITIONER

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED MAY 17, 1985
CERTIORARI GRANTED OCTOBER 15, 1985

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Oct. 18, 1978	—Federal Trade Commission Complaint issued.
Dec. 22, 1978	—Answer of Respondent Indiana Federation of Dentists filed.
Aug. 17, 1979	—Order of the United States District Court for the Southern District of Indiana directing that the State of Indiana be permitted to intervene in administrative proceeding.
Oct. 2, 1979	—Hearing commenced.
Oct. 17, 1979	—FTC concluded case in chief.
Oct. 29, 1979	—Intervenor commenced its case in chief.
Oct. 30, 1979	—Respondents presented defense in chief.
Nov. 1, 1979	—Intervenor concluded its case in chief.
Nov. 1, 1979	—FTC presented its rebuttal case.
Nov. 16, 1979	—Record closed.
Mar. 24, 1980	—Initial Decision and Order of Administrative Law Judge.
Feb. 17, 1983	—Final Order and Opinion of the FTC.
Apr. 28, 1983	—FTC Order Denying Petition for Reconsideration.
Oct. 11, 1984	—Opinion and Judgment of the Court of Appeals for the Seventh Circuit.
Dec. 21, 1984	—Court of Appeals' denial of petition for rehearing and suggestion for hearing *en banc*.
Oct. 15, 1985	—Grant of petition for writ of certiorari.

[EXCERPTS FROM TRANSCRIPT OF TESTIMONY]

TESTIMONY OF DAVID I. CHICHESTER
OCTOBER 3-4, 1979

* * * *

[396] Q Has CG requested preoperative X-rays in connection with the administration of these features?

A This is a standard approach for us, yes.

Q Can you give us reasons why your company does this?

A Our experience in looking at the administration of insurance is that dental insurance presents a rare, unique situation wherein we are dealing with one practitioner, one professional person as really the sole person who incurs expenses, compared to a medical claim where there are many sources of information that routinely come into us in processing of medical claims, such as a hospital bill, surgical bill, hospital record; all of that comes into substantially the medical claim, and in dentistry we have one professional involved. And so it is important to us to be able to substantiate that the work is actually as claimed, either the treatment plan or work is actually done as planned. Now, there are a number of ways of getting this information, but we believe that a picture is worth a thousand words, and that radiographs represent the most concrete and best documentation [397] that we could obtain. They are normally taken at the time the treatment plan is made, and so it's a normal part of the process that goes on in the dentist's office. So we have found that to be the most effective way to substantiate the claim.

Q Are the alternate benefit and predetermination feature as combined with X-rays as you've explained, cost containment features?

A Yes, they very definitely serve in that capacity. The alternate benefit allows us to contractually resort to payment of benefits that are consistent with good dental practice. It allows us, in a sense, to review that

in advance of the actual treatment. And there is some deterrent aspects to this as we see them.

MR. GRAHAM: We are going to object. I believe the witness is now beyond the scope of the question. He's offering his own opinion. If he wishes to cite some statistics as to what the deterrent aspects are, he's free to do so. He wasn't called as an expert, I—

MR. COSTILO: Your Honor, this man was involved in the initial design of the GM plan and in the predetermination features and alternate benefit features that were included in this plan. He had to discuss the reason for those features and why they were salutary for General Motors to sell them the plan. And in administering dental claims for Connecticut General, he's probably the best prepared person to say what [398] Connecticut General's reasons are for having these features. And with respect to the question of cost containment in particular, he's explaining why Connecticut General believed that and how they believed they would serve to contain costs, and now he's going into deterrents and I think he should be permitted to explain what he means.

JUDGE TEETOR: Objection is overruled. You may proceed.

A Thank you. So we feel very certain that the provision of radiograph as an illustration of documentation is a part of the cost containment because of the deterrent effect; when a dentist knows he has to send in X-rays to substantiate his claim, we believe that works as a deterrent, like the policeman on the beat when—

JUDGE TEETOR: Is "deterrent" to what?

THE WITNESS: To misrepresenting, overstating his claim.

BY MR. COSTILO:

Q Prior to the time that the GM plan became operational, did you have any contacts with dental representatives of dental organizations in regard to the GM plan?

A Yes, that was part of our development plan, the program for developing and preparing for—

* * * *

[432] Q Who was the first manager of it?

A Fred Roberts.

Q What was his relation to you in regard to Connecticut General's admission of general complaints?

A I selected him as manager for that office and he reported to me directly for at least two to three years.

Q What role, if any, did you intend Mr. Roberts to have in subsequent dealings with IDA representatives?

A My intent was to have Mr. Roberts be the focal point for all dialogues and to correlate all activities for the IDA. We had no desire to escalate that to the home office.

Q Did Connecticut General have any—strike that. You mentioned Dr. Pierce: Where was Dr. Pierce based, as far as doing his consulting work?

JUDGE TEETOR: Where was he what?

MR. COSTILO: "Based," physically based.

A As far as doing consulting work?

Q Yes, for CG.

A Our intention, we initially intended, and again nationwide, to have our consultant come into their office to do their work. I believe his office was in the home office, which was in Anderson. And so what occurred there was that, Anderson being so far from Indianapolis, was somewhat of a difficulty, just from a practical point of view, and just from [433] other things that developed, we allowed Dr. Pierce to operate from his base in Anderson.

Q Was it your preference that Dr. Pierce operated from Anderson rather than the Indianapolis claims office?

A No, absolutely not. This was a unique situation. It does not exist, to my knowledge, never did, anywhere else in the country. It raised some practical problems in terms of his being able to review claim files and documentation that came into the Indianapolis office, to send all the information, all information necessary to allow him to deliberate and for him to do his part of the consultative service. There was some risk involved in send-

ing our documentation through the mails to him. It precluded an opportunity to have any control on our part over his hours to make sure he did what we asked. It interfered with a very important relationship that our consultants have with other people in our office who also are working on those claims, in that when they are physically present in the office, they can sit down with the person, review the claims, get some history, and discuss it. This made it difficult when he did not come into the office and operate from his base in Anderson.

MR. FOWLER: Excuse me. Could I hear that answer back?

JUDGE TEETOR: The whole answer? How far back?

MR. FOWLER: Did I understand him to say that it [434] precluded them from talking with the dentists at CG's office?

JUDGE TEETOR: You answer that question.

THE WITNESS: It precluded their sitting down with our benefit analysis employees in our office, and discussing the situation.

JUDGE TEETOR: All right.

BY MR. COSTILO:

Q If this was not your preferable arrangement, why did you enter into it?

A It was the single optioned offered to us by the IDA at that time, to be able to avail ourselves of radiographs, because of the general resistence of sending radiographs to us. The single option offered by IDA to us was to have our consultants physically go into the practicing dentist's office to review X-rays. They acknowledged that it would be acceptable to them for us to have our dentists go into the practicing dentist's office. We felt that there were some strategic issues here because it was very important to us that we cooperate with them and try to work through this issue, particularly prior to the implementation of the business which was

still to come in October of '74. And we basically said okay, we'll try that in that location, since you are so resistent to sending them, and see how that works; knowing fully well that it was going to be highly impractical because all the practicing dentists that we use as consultants, we [435] pay them on a per-hour basis. And to expect a dentist in full-time practice and to expect to pay for a professional person like that, to go from office to office in town or something, that, we did not feel was at all workable. But we attempted to accommodate. In a sense, it was a compromise in order to demonstrate some good faith, and to establish, at least experiment with some means for getting the information we needed.

Q How did this arrangement contrast, if it contrasted, with the procedures used by CG to service the General Motors account in states other than Indiana?

A It was absolutely unique. To my knowledge, we had no other arrangement such as that.

Q Based upon your experience in dental claims, could Connecticut General successfully do business in those other states where it had offices under a consultant arrangement such as the one that you just described in Madison County?

MR. GRAHAM: I object.

MR. FOWLER: I object. This is pure speculation on his part. It's not material to this case, and the laws of the State of Indiana and to the other states may have differed, and the insurance companies know they have to do business in other states. It's not material to the IFD, and it's purely based upon speculation.

MR. COSTILO: Your Honor, this man is giving his [436] testimony as a person who is a businessman who is in charge of seeing that—as to how dental claims are administered with respect to General Motors' contract, and he is in a position to give his best judgment on whether CG could have operated this way if their arrangement was in existence in their other service accounts outside of Madison County, Indiana.

JUDGE TEETOR: I believe I'll let him answer that. Could they have done it elsewhere?

THE WITNESS: I don't think we could have.

JUDGE TEETOR: Why not?

THE WITNESS: The cost of the professional consultants nationwide to do that would be something that boggles my imagination. The consultants represented roughly ten percent of our budget as it was. Geographically, we would literally have to have hundreds, if not thousands, of these people in locals throughout the country to manage that many professional dentists. And that environment would be absurb, in my opinion. Further, just the logistics—

JUDGE TEETOR: This is another reason for your opinion?

THE WITNESS: Yes.

JUDGE TEETOR: All right.

THE WITNESS: As I mentioned earlier, the logistics of sending this documentation back and forth would be terribly [437] risky and something that we would not want to do. We would like those consultants to be in our office.

JUDGE TEETOR: Is that a good place to stop?

MR. COSTILO: Yes, your Honor.

JUDGE TEETOR: I'm going to look over this document that you handed me and maybe I'll ask for a little more discussion after we get back after lunch? Anything else to be brought up? All right. We will be back at 1:45 o'clock.

And you should be back here at that time.

THE WITNESS: Yes, sir.

JUDGE TEETOR: Until then, we're adjourned.

[Whereupon, at 12:13 o'clock, P.M., the hearing was recessed, to reconvene at 1:44 o'clock, P.M. this same day]

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TESTIMONY OF FRED ROBERTS
OCTOBER 4, 1979

* * * *

[689] A Yes, it remained at a very low percentage throughout the two years I was there.

JUDGE TEETOR: What's your present percentage?

THE WITNESS: Ten percent at the most. You're talking out of a population of forty dentists, two or three or four dentists that would submit X-rays on occasion.

BY MS. GEE:

Q Did Dr. Pierce review X-rays?

A Yes.

Q Where?

A He would review—We would submit cases to him to resolve, and he would review X-rays either in his office by calling the dentist and asking them to forward the X-rays to him, or physically going to that dentist's office and reviewing those X-rays there, and he would report back the findings that he came up with.

Q Did he review X-rays in all instances?

A I don't know, I can't answer that.

Q Was he instructed with respect to whether or not to review X-rays?

A Yes, in those situations where we—Yes, basically —Yes—Ask the question again.

Q Was Dr. Pierce instructed with respect to whether or not he should view X-rays?

A I don't know how to answer that because we are [690] relying on his judgment as a dentist and as a consultant to obtain whatever information he felt he needed to resolve the particular question, concern, problem that came up. There were some situations that we specifically asked for X-rays because it was the in-house consultant saying we need them to determine liability. There were others where we were leaving it up to his judgment to determine that, relying on him to determine it.

Q Was the arrangement of having Dr. Pierce handle Madison County dental claims satisfactory to you as head of the Indianapolis office?

A No, it was cumbersome.

Q And could you explain that?

A It involved setting up a separate system to deal with those claims that came from that area, outside the normal processing system that we had in the office. It involved additional clerical time, it involved additional expenses, it involved having to have an in-house consultant review the situation, determine that he didn't have enough information. So you had the in-house consultants' time involved, and in addition Dr. Pierce's time involved in it, so it was cumbersome, it added significant time to what it took to process a claim, which, in my mind, was a definite negative. And—

Q I'm sorry, I didn't understand your last statement. [691] A I said it added additional time to process claims. And to me, that was a definite negative to the way it was set up.

Q You mentioned extra costs. What extra costs would be incurred because of this arrangement?

A It involved the cost to pay the in-house consultant to get to the point of saying, hey, we got to forward this on to Dr. Pierce. In addition, Dr. Pierce's end, if it happened that he had to go out to the dentist's office, it certainly required time to physically go out and review one claim, and that was an additional expense. The additional clerical time to keep track of all the people and know where things were.

Q What basis was Pierce paid?

A All the consultants I had were paid on an hourly rate, they were paid for the number—they were paid for their time on an hourly rate.

Q You stated that the arrangement was not satisfactory. With respect to that arrangement, what if anything did you do to try to make it more satisfactory?

A In terms of trying to make that system work, what I said was we tried to make it work, we tried to give it

time to settle in, to make it work efficiently and not add additional costs; and we couldn't.

Q And you could not, you say?

A We could not. • • •

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TESTIMONY OF JOHN E. SPEZIALE
OCTOBER 5, 1979

• • • •

[812] Q What position?

A Senior Account Executive.

Q What position did you hold with the company immediately prior to that?

A I was Regional Manager of the Indiana Dental Claims Office for Connecticut General.

Q And during what period of time were you Regional Manager of that office?

A From May of '76 through November of '77.

Q Before you came to the Indianapolis office, what did you do immediately before that for the company?

A I was Assistant Manager of our Meridan, Connecticut Dental Claims Office.

Q And before that?

A I was Assistant Manager of our Bristol, Connecticut Medical Claims Office for approximately three years.

Q How long have you been working for C.G.?

A Just about eight and a half years.

Q At the time that you started your job in the Indianapolis office, was the company receiving X-rays from dentists in Madison County?

MR. GRAHAM: Objection, Your Honor. He's generalizing again. I wish he would phrase his questions in terms of particular dentists. Now we're [813] talking about the whole county in general. I would like to see the questions a little more specific. He's taking the whole county in one question.

MR. COSTILO: I want to find out his experience, whether he did, and if so, to what degree. I think it's a perfectly proper question.

JUDGE TEETOR: Overruled. You may answer.

A On very, very rare occasions.

Q With respect to those rare occasions when you did receive them, did the dentists openly submit the X-rays to the office?

A On the few instances that it did in fact happen, they had voluntarily been submitted, but followed up by a phone call from that particular dentist asking us to make sure that nobody else knew they were in fact submitted to our office.

Q With respect to the situation as pertained to the degree of submission of X-rays in Madison County, how did that compare to the rest of the State of Indiana when you came to your job?

MR. GRAHAM: We'll object, Your Honor. There has been insufficient foundation laid. This man was only Regional Manager of the Indianapolis office. There is no evidence that he has statistics for the rest of the State of Indiana.

[814] BY MR. COSTILO:

Q Did your job responsibilities include processing of claims for the entire State of Indiana from the Indianapolis claims office?

A Yes, I had responsibility for all of Indiana and Kentucky.

Q Were you familiar with the extent to which X-rays were submitted to that office from other parts of the State of Indiana other than Madison County?

A Yes, I was.

Q How did the degree of submission of X-rays for the whole state except Madison County compare to the experience with which you just related as to Madison County?

A Receipt of radiographs from areas outside of Madison County were far superior from that received from Madison County.

JUDGE TEETOR: What is "far superior"? Give me some percentage ideas here.

THE WITNESS: Seventy per cent from other areas of the state versus one per cent in Madison County.

JUDGE TEETOR: One per cent?

THE WITNESS: Yes, if that many.

* * * *

[816] Q With respect to your claims review operations, what was the arrangement that C.G. used in Madison County?

A We hired a local consultant in the City of Anderson, Indiana to assist us in determining claim reimbursements. It was physically housed in Anderson, rather than having him work out of our Indianapolis office.

Q Was this arrangement one of preference from Connecticut General's standpoint?

A Not at all.

Q Can you explain why not?

A Yes, because it was more expensive for us to administer the claims that way; secondly, there were inherent delays in claim reimbursements back to our insured members; and thirdly, it was virtually impossible —let me see if I can go back a second. I think any kind of claim operation is an evolution. It's a constant [817] changing thing, philosophies, etc. from the corporate levels. By having my consultants in my office in Indiana, we had an opportunity to get together frequently, discuss these things, get down some of the gray areas as to how we wanted things to be administered.

By having Dr. Pierce in Anderson, it was virtually impossible to keep the ongoing dialogue between the two, and therefore I felt he wasn't in tune with the most recent philosophies of Connecticut General.

Q Do you know whether or not this arrangement caused any problems for Dr. Pierce?

A Yes, it did. He was in a rather unique position wearing the hat of a consultant for an insurance carrier, and at the same time being located in an area that was resistant to what we were trying to accomplish, and

I felt—and he expressed to me on a number of occasions a lot of peer pressure upon him.

Q Even though this arrangement was not—

JUDGE TEETOR: Just a minute. What was the peer pressure? Regarding what?

THE WITNESS: Regarding specifically the X-ray issue, more than anything else, sir. They were constantly making sure that Jim Pierce—Dr. Pierce, excuse me, worked within their standards of acceptability, versus what Connecticut General's standards of [818] acceptability were.

Q Even though this arrangement, Mr. Speziale, was not one of preference from C.G.'s standpoint, was it workable?

A It was workable, yes. Again, it wasn't out of preference, but it had—by the time I got there, it had been in existence for two years and we managed to work within the framework of it.

Q Did you ever have occasion to meet with State Commissioner of Insurance Hudson?

A Yes, I did.

Q Approximately when?

A In July of '76, I believe.

Q And where did that meeting take place?

A In Commissioner Hudson's office.

Q What were the circumstances that led to the meeting?

A I had been requested submission of radiographs on a specific claim. The dentist in question submitted a complaint to the Insurance Commissioner against Connecticut General for my taking those actions. When I was notified by the Insurance Commissioner as to the inquiry, I felt that was a very good opportunity for me to get to meet Commissioner Hudson, so that's what prompted the meeting.

* * * *

[871] JUDGE TEETOR: You may answer the question.

A Yes.

Q What were the circumstances?

A There were occasions when I saw the need—I guess you would say test the waters and see what kind of reaction I would get by so doing. I do not honestly remember of the specifics of the given claim in question, but I'm sure it was one that we felt very strongly we needed X-rays and I requested them directly from the dentist to be sent to our Indianapolis office.

Q Approximately when was this?

A Very nearly 1977, I would say.

Q What happened after you made this request?

A Shortly thereafter, certainly within a week, I had received a phone call from Drs. Pierce and Rohn wanting to know why I had requested such X-rays and if in fact our policy had changed. I did not get the phone call from the dentist who was being requested the X-rays.

MR. FOWLER: Your Honor, may I inquire for a point of clarification did I understand the witness to say in several occasions he had the desire to sort of test the waters? And now he's referring to apparently one of those occasions, but I don't understand when that occasion was [872] among the chain of events that he's talking about.

JUDGE TEETOR: Fix a time and place, if you can.

Q Can you give us the time and place of this incident?

A I can do it as closely as I can, and I would say very early in 1977—January, February, 1977.

JUDGE TEETOR: Did you say Pierce was in Rome?

THE WITNESS: Did I say that? I didn't mean to, if I did.

MR. COSTILO: Let's clarify the point.

Q You said you received two phone calls thereafter, is that correct?

A Yes, I received a call from Dr. Pierce and from Dr. Dan Rohn.

Q Were they on the same phone or where they separate calls?

A Separate calls, again wanting to know if in fact our policy had changed and why I took such action.

Q What if anything happened next?

A That was followed up by a request on the part of three or four dentists in Madison County for me to come up there and attend a meeting with them to discuss some general issues and problems, namely the X-ray submissions, again prompted by this request, assignment of benefits for providers and charges for filing claim forms with the insurance [873] company as an administrative cost.

Q Who were these dentists? Let me backtrack one second. Did you meet with the dentists?

A Yes, I met with them in Anderson one evening, and I believe it was in Dr. Clevinger's office. Present at the meeting were Dr. Clevinger, J. Wooster, Boyle, and I'm not sure is Dr. Janzaruk was present or not. I really can't remember.

JUDGE TEETOR: Who?

THE WITNESS: Dr. Janzaruk.

Q Where was the meeting? Do you recall?

A Yes, it was in Anderson. Again, I think it was at Dr. Clevinger's office.

Q What occurred at the meeting?

A Well, we sat down in an informal environment and discussed some mutual problems that opened up with the X-ray issue.

Q What did they say on that to you?

A Again, they were questioning me and Connecticut General to see if in fact our policy had changed, were

we in fact going to request X-rays directly from dentists in Madison County, which meant sending them directly to our Indianapolis office, and I said yes, on occasion that we were going to do that. We in essence had not changed our original position.

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TESTIMONY OF ERNEST MISHLER
OCTOBER 5, 1979

* * * *

[917] Q In the course of your duties for Connecticut General, do you ever have occasion to speak with the treating dentist, the dentist who submitted the claim form or signed the claim form?

A Oh, yes.

Q In what case do you talk to the treating dentist?

A I never make an alternate treatment or invoke alternate treatment without first consulting with the dentist involved.

Q Are there any other occasions when you would speak to them?

A Yes, to get additional information of any kind, even in making another determination, I mean of an approval, the same way as an alternate treatment plan, I also contact dentists for those reasons.

Q Were you through?

A Yes.

Q When you speak with the treating dentist on the possibility of an alternate benefit, raising that or an alternate treatment, I presume, how do dentists generally respond, if you can recall?

JUDGE TEETOR: Can you generalize about that, Doctor?

* * * *

[947] JUDGE TEETOR: Is this assuming that he has had access to the X-ray first?

MR. FOWLER: No X-ray.

JUDGE TEETOR: No X-ray, just the talk.

BY DR. MISHLER:

A It certainly would be much easier if I could visualize what we were discussing, what we were talking about. It's certainly much, much, much easier. The dentist is not always available to talk to, either.

Q Even with the X-ray, I believe you said you would call the dentist before you would invoke—

A Invoke the alternate treatment because I want to find out any additional information he might have in line with what you were talking about a while ago, that no, I cannot rely on X-rays alone to make a determination. I must have additional information before I would invoke an alternate treatment. In many cases I also would ask for additional information in approval, in spite of the fact that I have the X-ray in front of me, because I cannot make a complete determination from an X-ray. It requires the combination.

Q How concerned are you, as a consultant of C.G., with the possibility of fraud by one of your fellow dentists?

A How concerned am I with it?

Q Sure.

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TESTIMONY OF GERHARD R. SCHADE, JR.
OCTOBER 9, 1979

* * * *

[974] Q Why does Aetna have cost and quality controls in its dental plans?

A We feel that in administering employee benefit programs we have to add some value to the product; that anybody can just pay every bill that is submitted without question; that if we are going to distinguish ourselves from our competitors and succeed in the marketplace, that we msut add value to the product by bringing to bear some special expertise in the area of cost and quality controls.

Q Are cost and quality controls important to Aetna, in its dental plans?

A Yes.

Q Are you familiar with the term "alternate benefits" in group dental plans?

A Yes.

Q How are you familiar with that?

A This is a common contract provision that's included. It's a standard part of our standard dental product. It's sometimes referred to as alternate benefit; or, sometimes in the contract, the heading is alternate treatment.

Q Could you explain briefly what this term means or what it is?

A Yes. This term is an effort to define the level of care for which benefits are provided. In dental treatment, [975] there are often alternative treatments which may be used to treat a particular dental condition. We felt it was important, in our contracts, to define the level of treatment that we intend to provide reimbursement for. Basically what we are aiming at is good quality treatment that's broadly accepted by the dental profession, based on national standards. We are trying to rule out excessively elaborate treatment or Cadillac care.

Q How does it work, the alternate benefit feature? Could you give an example?

A All right, an example is that—First, I should explain that this plan provision is always accompanied by a claim predetermination of benefits feature, whereby the patient and the dentist can prefile with the insurance company in advance of starting the course of treatment, can prefile the proposed treatment that is anticipated, and the proposed charges that will be made for that treatment. This is submitted to our claims office, and our claims office then provides a preestimate of the benefits that will be allowed, will be payable for that proposed course of treatment.

In doing this, if the proposed treatment appears to—there are alternatives for that particular type of treatment—it is submitted to a dental consultant for review and professional advice.

This is where I might bring in that, in reviewing this kind [976] of claim, the dental consultant reviews pretreatment x-rays which were submitted with the claim submission or the predetermination submission. If there are any questions of a professional nature that arise in our consultant's mind, he calls the attending dentist to discuss these questions and gather additional information.

The consultant then, after this conversation, makes his recommendation, gives his professional views. Then the claim processor would make a benefit determination, taking into account the advice from the dental consultant.

Now if it is determined that there were alternatives which are broadly accepted, we would base the benefit predetermination on the alternative treatment.

Q You mentioned that your consultants review x-rays—

A Yes.

Q —in connection with the alternate benefits feature.

MR. GRAHAM: I am going to object, your Honor. I don't believe that's in the evidence.

JUDGE TEETOR: Is that what you think you said?

THE WITNESS: Yes, I said that. I did say that, I believe, if you [the reporter] will confirm that.

MS. GEE: Shall I have the—

JUDGE TEETOR: Go ahead.

Q What role do x-rays play in the benefit determina-
[977] tion for contracts with alternate benefits?

A The review of x-rays by a consultant is the most practical, feasible way for our consultant to get a first-hand knowledge of the condition of the patient's mouth before the treatment was rendered. In administering the plan, the contract says that we will take into account the total oral condition of the patient in deciding on alternate treatments; and the review of x-rays is the most feasible, practical way for the consultant to get information on the patient, the condition of the patient's oral health.

Q Could you explain in more detail? You say it's the most feasible, most practical.

A Yes.

Q What the alternatives would be or why you believe it is the most feasible and practical?

MR. GRAHAM: Judge, we are going to object to that question. I don't think this man is qualified to answer that question with respect to x-rays.

JUDGE TEETOR: Let's develop a little more about what he knows about x-rays.

MS. GEE: Pardon me?

JUDGE TEETOR: Develop a little more about what he knows about x-rays.

THE WITNESS: Should I answer that question?

JUDGE TEETOR: No.

[978] MS. GEE: I think I will go on.

JUDGE TEETOR: Well, let's not be too formal. What was your statement then?

THE WITNESS: Well, the question was what are alternatives?

MS. GEE: Let me restate my question, your Honor.

JUDGE TEETOR: All right.

Q From your standpoint in claim policy, why does it appear to you that x-rays are the most feasible, practical tool for benefit determination or for review by dental consultants?

A Well, one important consideration, from the point of view of claim policy, is that our claim procedures must be economical to administer. We have millions of claim transactions annually. We have to operate efficiently and economically. The review of x-rays is a relatively economical procedure to be followed in the claims office by a dental consultant.

MR. FOWLER: Relatively what, sir? I didn't hear.

THE WITNESS: Economical.

Q Compared with what?

A Well, compared with calling each patient in for a personal examination or compared with visiting the dentist's office to review his records in his office.

Q Is the alternate benefits feature a cost-containment
[979] mechanism?

MR. GRAHAM: Objection, your Honor. That calls for a conclusion. If he would like to state some facts or some circumstances that would tend to show that, that would be fine. But she is asking for a broad conclusion by this particular witness.

JUDGE TEETOR: Overruled.

A Alternate benefit provision is commonly referred to as a cost containment, because in the absence of this particular policy provision the cost of insurance would be higher.

Q Are you familiar with the term—I believe you mentioned the term—"predetermination" in dental plans?

A Yes.

Q Could you explain briefly what that means?

A Well, this predetermination is a claim procedure whereby the dentist and the patient can prefile with the claim office proposed course of treatment in advance of its being started, so that to allow the claim office an opportunity to provide a preestimate of the benefits that will be payable for that course of treatment. This then

allows the patient and dentist to make their plans on the course of treatment to be followed, to discuss this in advance, knowing fully what the benefits—what benefits will be payable under the plan and what the financial obligations of the patient will [980] be. And I might just add that it's normally aimed at the more extensive courses of treatment which would cost over a certain dollar threshold amount, usually a hundred dollars, a hundred and twenty-five or a hundred and fifty dollar threshold.

Q What is the relationship, if any, between alternate benefits feature and predetermination?

A Predetermination is always included in a plan that has alternate benefit provision. They go together; because, without the predetermination feature, the patient and dentist would have no way of knowing until after the fact, about the benefit determination. And there could be surprises, which would be undesirable.

Some plans that do not have alternate benefit, however, also do have the predetermination feature.

Q Does predetermination control costs?

MR. GRAHAM: Objection, your Honor. If he has some statistics, I would like to hear them; but this is, once again, a similar question to the alternate benefits where he gave a general answer. I would like to hear statistics. That's a general question, and we object to it.

JUDGE TEETOR: Overruled.

A Predetermination, all by itself, does not in my opinion control the cost of insurance, no.

Q If predetermination is used with alternate benefits, [981] is this a cost containing combination?

A Yes.

Q Can you explain how costs are contained in that situation, where the two are combined?

A Yes. I explained earlier that under the alternate benefit provision we will not reimburse for the more elaborate excessively Cadillace treatments and that benefits will be based on the conventional broadly accepted

method of treating the condition. The broadly accepted method of treating the condition costs less than the Cadillac method of treating the condition. So, there is a difference there. That difference is the amount by which the cost of insurance would be held down.

Q Thank you.

Whose costs are contained, in the situation you described?

A I discussed that it holds down the cost of insurance. The cost of insurance is normally financed by the employer that sponsors the benefit program. There are sometimes employee contributions towards that cost, but the bulk of the cost is normally financed by the employer. So, this is a control on the cost of insurance.

Now can there be reduction—

MR. FOWLER: Your Honor—

THE WITNESS: Excuse me?

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[1169] MS. GEE: Thank you. That's all we have.

JUDGE TEETOR: Any recross?

Whereupon,

RECROSS-EXAMINATION

BY MR. FOWLER:

Q Mr. Schade, the abuse that you are talking about, how do you conclude that the x-rays caused that?

A Our consultants can verify the diagnosis by reviewing the x-ray, whether it's a complete impaction or not, through review of the x-ray and discussion with the dentist. It makes it possible for the consultant to verify and review the diagnosis.

Q Did you conduct statistics on that problem?

A In the early days, there were some statistics. But, as I say, I don't have figures with me.

Q Well, isn't it a fact that the problem was perhaps due to your coding as well as x-rays?

A The coding system?

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TESTIMONY OF WILLIAM G. DOWNES, D.D.S.
OCTOBER 10, 1979

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[1267] Q With respect to Dr. Bohnke, he was the dentist who was from near the Fort Wayne area. Is that correct?

A That's right, yes.

Q Do you know what dental society he was a member of?

A The Isaac Knapp Dental Society.

Q And that society, what relationship does that society have to IDA?

A It's—and I am not sure of the word—it's a component or a constituent. I think it's a component of IDA.

Q What did Dr. Bohnke do for you, when he came to work?

A When he came, for us?

Q Yes.

A In essence, he reviewed the claims and the radiographs that were received by our Fort Wayne office and, on the basis of that, answered certain specific questions that were asked of him by our claim people in Fort Wayne, as a basis of recommending a benefit payment. There was also one other primary function that Dr. Bohnke performed for us for a specific period of time.

Q What was that?

A Because there were a substantial number of patients upon whom we were unable to determine the maximum benefits, we had worked out with International Harvester a commitment to [1268] once again review all of those claims directly in the offices of the dentists and have Dr. Bohnke visit all of those dentists and go over every single one of those claims that had been submitted since July of 1971, to see whether or not there were some additional benefits that could be payable once Dr. Bohnke was able to see the x-rays in the dentists' offices.

Q How may claims were involved here?

A There were over six hundred claims.

Q Did Dr. Bohnke request dentists to submit x-rays?

A Yes.

Q Do you know what response if any the Isaac Knapp Society had to these requests that he was making?

A The requests for x-rays or the appeal to member dentists to submit x-rays?

Q Dr. Bohnke's appeal to dentists to submit x-rays.

A Okay, because to that they were saying that Dr. Bohnke was running a substantial risk of acting unethically and that he could be censored by the Isaac Knapp District Dental Society for persuading dentists to submit x-rays.

Q Do you know whether or not they took any action in that regard?

A I—

MR. GRAHAM: Your Honor, we are going to object.

JUDGE TEETOR: The question is does he know. You may answer the question.

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[1274] AFTERNOON SESSION

[1:45 p.m.]

JUDGE TEETOR: The hearing will be resumed. You may continue with your examination.

Whereupon,

WILLIAM G. DOWNES

resumed the stand and, having been previously duly sworn, was examined and testified further as follows:

DIRECT EXAMINATION [continued]

BY MR. COSTILO:

Q Dr. Downes, I believe this morning you testified that there were a number of cases, approximately six hundred that you were aware, where x-rays were requested and not submitted and where Aetna was going

to do follow-up visits in the dentists' offices. Is that correct?

A That's right.

Q Was that Dr. Bohnke who was going to do this?

A That's right.

Q Did he in fact go to the offices of the dentists?

A Yes, he did.

Q Did you go along with him on any of these visits?

A I spent two days going with him, yes.

Q What's our time frame here, as best you can place it?

A I suspect it's the last quarter of '72 and the first [1275] quarter of '73.

Q When you went to the dentist's office, did either you or Dr. Bohnke request that the dentist submit x-rays?

A After we discussed cases, yes.

Q What responses did the dentists give in connection with that?

MR. GRAHAM: Your Honor, we are going to object to that broad generalization of dentists. Now if he went with Bohnke and visited some dentists, I think we are entitled to know the names of these dentists that said this, instead of a broad generalization.

JUDGE TEETOR: Sir, is it possible to generalize about those responses?

THE WITNESS: Yes, it is.

JUDGE TEETOR: Go ahead.

THE WITNESS: There were two general reactions: one, dentists who said despite the fact that you seem fair, I will not send x-rays to you; and others who said I would like to, but I don't dare to.

BY MR. COSTILO:

Q Did Dr. Bohnke complete these visits then?

A Yes, he did.

Q Were claims paid on the basis of those visits?

A Many of the claims, additional benefits were paid, yes.

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TESTIMONY OF DR. FRANK MIELE
OCTOBER 11, 1979

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[1433] MR. GRAHAM: Your Honor, we're going to object. I think he's guessing. He's saying, "We think that probably—" I think that's pure speculation. If they have a study, I would like to see it. I think he's just guessing as to what savings are caused by what, if any.

JUDGE TEETOR: Overruled. Go ahead.

BY DR. MIELE:

A (Continuing) We suspected that it was the dentists probably testing the system. This was the first experience for them in sending in X-rays.

Q What do you mean by "testing"?

A Well, they had limited experience or none at all in dealing with third party programs, and we found that in those early plans when a plan just went into effect we saw an awful lot of work come in for cosmetic dentistry, even though cosmetic dentistry is not covered in the plan.

When we would ask for the X-rays we would have the dentist submit the X-rays and we would see there was no pathology; it was strictly a matter of teeth being slightly rotated or color not being perfect for the patient, and they wanted something that was cosmetic.

I personally did not call the dentist. Obviously I was not involved in this, but my consultants reported to me [1434] because I wanted to find out what was the real cause here.

The treating doctors would usually say something to the effect, "Yeah, we know it's cosmetic, but we weren't sure there was a dentist to review the X-rays. The patient wants the work and we're trying to help the patient get their benefits, and we understand it's not covered." So there was testing, no doubt about it.

Q You mentioned that the oldest plan you tested was a two-year plan?

A Yes.

Q Were there still significant savings?

A No, I wouldn't say they were significant but there were measurable savings.

Q Why would you continue to have alternate benefits in a plan over two years old if your own studies showed—

A I guess our own suspicion—and again, it's our own suspicion—if we removed the cost containment vehicle, if we remove the dental consultant from the scene, we're afraid that they may go back to testing the system again. We know this works. We know the dentists can work with it in the vast majority of areas and we see no reason to discontinue it.

Q Are you familiar with the term "predetermination"?

A Yes.

* * * *

[1439] Q Do your dental consultants ever talk with the treating dentist?

A Yes.

Q In what circumstance would that occur?

A When an alternate benefit is to be invoked or there is any question about what is appearing on the X-ray, our consultant will call up the treating doctor and discuss the case.

Q That means in all cases of alternate benefits?

A Yes, or any question.

Q You mentioned as part of your work in the earlier years at Metropolitan you frequently contacted dental organizations in areas where new plans were going in. Did you ever have such contact with Indiana dentists?

A Yes.

* * * *

[1511] Q If we're getting beyond what we know, don't let me lead you into it. We don't want a misstatement here. As I understand those type things, the corporation

extracts from the treating dentist a certain percentage of this usual and customary fee that they agree to charge and withhold that?

A That was true in the early days. I don't know if it exists today.

Q You mentioned that you made a study I guess of day one, nine month and two-year plans, and after a plan was in effect for two years you found the savings, and the words you used were, "no longer significant as to alternate benefits?"

A I said they were measurable.

Q Measurable?

A Right.

Q As I understand you to say—am I correct in this—you continue to sell those or stress those because you believe that if you didn't, the dentist would go back to testing the plan somehow?

A Yes.

Q So what it is is a fraud control?

A I think it's even more than fraud control. I think we get into necessity of care also; in other words, [1512] overutilization. It's certainly not fraud.

For example, if I may just elaborate a bit, the doctor who is submitting a claim for cosmetic dentistry is certainly not submitting a fraudulent claim because a good deal of dentistry is cosmetic in nature, and if a patient comes in and has funny colored teeth and wants them capped, there is no earthly reason you don't cap them because it's a cosmetic service. So therefore, what can happen is a doctor may submit a claim and write down, "Crowns on teeth six to twelve," and that's it. However, the X ray would reveal there was no pathology. It would elicit a call to the doctor and say, "Hey, what's going on?" "It's a cosmetic consideration." "Well, it's not covered." "Thank you very much."

But that's not a fraudulent claim, so I don't want you to think that's all it's used for, but it helps overutilization and modifies necessity of care.

Q What is predetermination?

A Strictly communication.

Q Predetermination in that process is also strictly a costly procedure itself, isn't it?

A I don't know how costly it is. I don't think anyone has really—we never really measured what it cost, but I think that it's very necessary. In order to at least communicate with consumers, I think it has that effect.

TESTIMONY OF STEVEN CHRISTIANSON
OCTOBER 12, 1979

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[1614] Q When you assumed your position at Lapel, were there any problems with the administration of the dental claims?

A Yes.

Q How did these problems come to your attention?

A When I was at Clarksburg, we didn't have any problems with the dental program.

Q When you got to Lapel, how did you learn that there was a problem?

A Employees and the union.

Q What was the problem?

A The dentists in Anderson were refusing to submit X rays to the insurance company so that benefits could be paid.

Q How did this appear to be a problem to you as a personnel manager?

A Personally, it's an employees relation problem. Secondly, these people have benefits and weren't able to collect on them.

Q What did Metropolitan do when X rays weren't received?

A They would make attempts to get in contact with us to contact the dentist to try to persuade them to submit [1615] the X rays so that the benefits could be paid. If the X rays weren't submitted, they didn't pay.

Q Did you take any steps to try to resolve the X ray problem?

A We had contact with—called some of the dentists complaining about our problem.

Q Pardon?

A We called some of the dentists to explain our problem, that we just wanted the X rays to be submitted to Metropolitan for their review, and then they would be sent back.

Q Were these phone calls successful?

A No.

Q What was the response that you got from the telephone calls, if you recall?

A One I recall, the dentist was concerned that, first, that we were making the determination in our office, which I told them we weren't. Secondly, that it was his property and he didn't want to send it to Metropolitan, he feared it would be lost and he couldn't retrieve it. I told him that wouldn't be the case.

Q You remember who the dentist was?

A No.

Q Did you take any other steps other than telephone calls?

[1616] A We would—

JUDGE TEETOR: Excuse me. Are you saying there was just one call that you made?

THE WITNESS: One call that I remember.

JUDGE TEETOR: You think you made others?

THE WITNESS: Yes. I, or our department, would write letters also to the dentist.

JUDGE TEETOR: Is there any way of estimating about how many?

THE WITNESS: No.

BY MS. GEE:

How often would you make a phone call or write a letter?

A That would depend on the dental claim. We had a deductible, and every dental claim would need X rays. If it didn't meet the deductible, the employee would pay anyway, so—

Q You stated that you wrote dentists as well?

A Yes.

Q What type of letter—What did you write them?

A Just a letter requesting them to submit X rays to us so that we could forward them to the insurance company in hopes of settling the claim.

Q Were the efforts through letters successful?

A No.

[1617] Q Did you continue to make phone calls?

A Yes.

Q And write letters?

A Yes, the routine process to send a letter to the dentist.

Q Did you ever have occasion to speak with—Excuse me, let me back up. Do the employees of Brockway Glass Company belong to a union?

A Yes.

Q What union?

A Glass Blowers Association.

Q Did you ever have occasion to speak with any representatives of your employees' union regarding the X ray issue?

A Two; immediately after my arriving at the plant, Betty Jennings was the president.

MR. FOWLER: Betty?

THE WITNESS: Betty Jennings.

BY MS. GEE:

Q Go ahead.

A And there was an election, union election, in the fall of that year. And Rex Passwater was elected president, and I talked to him about it, or he talked to me about it.

Q You said you spoke to Jennings about the problem?

A When I initially arrived at the plant.

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TESTIMONY OF JACOB HURWITZ
OCTOBER 15, 1979

[1767] Q Did the plan that was agreed to and subsequently went into effect have predetermination and alternate benefits features?

A Yes, they were written into the initial agreement.

Q What if any way do these features serve the objectives you stated? Let's start with cost control.

A Well, the predetermination and the availability of —well, combined with the alternate course of treatment, represents I guess both, in my view, both a cost control and a quality control in that— I will cover each one of those items.

In terms of a cost containment aspect, we have learned that in dentistry there generally are—for any given problem, there may be a number of alternate solutions. Dentally speaking, there may be different ways of treating the same condition. And the cost of the different methods of treatment may vary and generally do. Now we feel an obligation to provide care at an acceptably, professionally acceptable level, but we are not interested in providing and spending our members' money for cosmetic, if you will, dentistry or [1768] extraordinarily costly kinds of dental service; so, the idea of the predeterminaiton in terms of cost control is to arrive at where the patient and the dentist discuss the form of treatment to arrive at a level of treatment that is dentally sound and adequate and it provides a reasonable level of care without automatically allowing the dentist to provide the most expensive form possible. It lso works as a quality control in that when I have discussed this with some of the carriers that we work with, they have pointed out to me that on occasion they will, the dental consultant, the carrier's dental consultant will discuss with the attending dentist whether or not a proposed course of treatment is good enough and might suggest, through discussion with the attending dentist, that he might upgrade the level

of treatment that he is providing, to a more adequate level. So in that sense, it can also function as a quality control as well as a cost containment.

Q What if anything has the UAW done with respect to the plans to insure uniformity of administration?

A Well, we start out initially by writing into the agreement, the bargaining agreement with the employers, a uniform program insofar as, well, the program that applies throughout the country in all of the various locations that the auto employers have facilities and it's the same program that applies to all of them. Subsequent to that, we developed [1769] an administrative manual which all of the carriers are involved in, well, who are involved in the administration of the dental program. The administrative manual was developed jointly between UAW, the automobile companies and the various carriers involved, with the specific idea of achieving a maximum degree of uniformity.

Q Did the UAW want alternate benefits and predetermination in the plan?

A Yes. I think that was always part of our idea of what should go into the program, when we negotiated it.

Q D[illegible] the automobile manufacturers want these features?

A Well, I don't have any reason for believing that they didn't. I recall in negotiations at Chrysler in 1973 that we did exchange a proposal for it, after the principle of establishing a dental program was agreed to. I think we did exchange a proposal, and I know it was in our proposal and I am not sure if it was in theirs. But it was never a subject that I recall of any great controversy. It was definitely a part of the initial program.

Q What did you understand the role to be, if any, of preoperative x-rays in administration of the UAW dental plan?

A Well, the preoperative x-rays were a tool for the benefit of the dental consultant, the carrier's dental consultant, to evaluate the proposed course of treatment by

[1770] the attending dentist and he would rely on them for making a determination of the adequacy and appropriateness of the course of treatment proposed by the dentist.

Q Was submission of x-rays to the carrier specifically anticipated in the bargaining agreement?

A As I recall, it was.

Q Has the UAW dental plan been successful, from UAW's standpoint?

A Yes, I think we regard it as a highly successful benefit.

Q Do you know whether predetermination and alternate benefits have helped contain costs?

MR. FOWLER: Your Honor, we let this witness go well beyond his expertise as laid by any foundation she may have laid. We have had, I think, witnesses from each of the companies in here that are directly involved in underwriting the auto industry contracts as they affect this case, and I think the evidence is quite clear that there's only one of them that has said any more than speculation in his testimony.

JUDGE TEETOR: This is just a do-you-know question. Let's hold it to the answer. It may not be a problem.

Would you repeat your question?

BY MS. GEE:

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[1772] Q How frequently do you get the last type of report?

A Those are annual reports.

Q Does the information you receive indicate to you whether or not predetermination has helped to contain costs?

MR. FOLWER: To which we object, your Honor, again. This man's indication is purely from hearsay documents. There is no way that we can test him, even by cross-examination. They have had the insurance compa-

nies in here involved. If those people don't have the facts, then they misinformed this hearing, number one. But their testimony is on record, and this man is not connected with the insurance company to be able to give us credible facts on this thing.

JUDGE TEETOR: Ms. Gee, why is his opinion of legal significance here?

MS. GEE. Your Honor, what I was trying to establish—and perhaps I could ask a separate question to get this—is whether or not Mr. Hurwitz, who represents the United Auto Workers and has an interest in assuring that they have the kind of plan they want, whether he feels satisfied that these features have served their intended purpose.

JUDGE TEETOR: Whether the union is satisfied.

[1773] MS. GEE: That this objective which was important to them has been achieved.

JUDGE TEETOR: For the simple purpose of stating whether or not the unions are satisfied, the UAW is satisfied, I will take his answer, but no more—just that simple question.

THE WITNESS: I think we are reasonably well satisfied.

BY MS. GEE:

Q That these provisions help contain costs.

A Yes.

JUDGE TEETOR: Incidentally, Ms. Gee, are you going to put in any examples of these type of reports he is talking about? That seems to me that's first-line evidence.

MS. GEE: Your Honor, I have been assured by Mr. Hurwitz that these reports are highly confidential and that they are provided to the UAW under fairly severe confidential arrangements. And since we are not putting in the data—I haven't seen these reports he is talking about. I am wanting to lay a foundation that he has something other than speculation with respect to this.

But as I say, the point is to show that the United Auto Workers are satisfied that the provisions they have do what they are intended to do.

JUDGE TEETOR: I understand your theory, but it seems to me like this is very valuable evidence.

[1774] As far as confidentiality, we have that problem all the time, and there are arrangements that we may keep those things sealed. I am just a little puzzled that you haven't put them in.

Do you have any intention of putting something like that in, Mr. Fowler?

MR. FOWLER: I don't know as I even have any such documents, your Honor. I tried to get one in which showed the relative cost per employee or something of that nature and couldn't get that in. That was the only one I recall having. That was comparing Connecticut General with Aetna and whoever else had the auto's plan.

JUDGE TEETOR: I excluded it?

MR. FOWLER: Somebody did. I couldn't get the witness to identify it, Judge.

MS. GEE: I don't think you offered it.

MR. FOWLER: I couldn't get the witness to identify it. That was the problem.

JUDGE TEETOR: Let's make that clear then.

MR. FOWLER: Yes.

Now this is the whole problem we have got here. We have had these people in here who are directly responsible, from all of the background they have given, your Honor, about how much importance they had in establishing these plans on behalf of their respective companies. And the evidence, I [1775] specifically recall, from each one of them was: We don't know. It's speculative. Its intention was to be cost containment, but they really didn't know. They didn't keep records. They never had statistics.

Now this man comes along and is alleging that they have some kind of statistics. I suggest that the direct

examination and the evidence presented through these insurance men has been seriously questioned by his testimony if there indeed are those statistics. I am a little upset about it.

JUDGE TEETOR: Mr. Hurwitz, did you bring any of those annual reports with you?

THE WITNESS: No, I didn't.

JUDGE TEETOR: And where are they?

THE WITNESS: They are in our office in Detroit.

JUDGE TEETOR: In Detroit?

THE WITNESS: [Affirmative nod]

MS. GEE: Your Honor, if I might add, I want to mention also that the theory of our case, as we stated before, is not that we must show that in fact these provisions do contain cost. I mean that isn't important with respect to the allegations in the complaint.

We are stating that when collective action interferes with what business entities desire to do, you have a combination of competitors which exert pressure on those business decisions, that you have an antitrust violation. And whether or [1776] not what the private economic entities desire to do is beneficial or not is really not the point. If they want to do that and they believe it to be so, any interference by collective action would violate the antitrust law.

JUDGE TEETOR: Excuse me just a minute, Mr. Graham.

I understand that; but, nevetheless, there has been a lot of evidence about this cost containment and the mechanics of predetermination and alternate benefits and so forth. And again, it looks to me like this is a gold mine of information which is just puzzling me that you didn't put in.

Mr. Graham?

MR. GRAHAM: Well, your Honor, I just think it's interesting that based on their theory, if insurance companies told every dentist in the state of Indiana to jump

in the lake and they refused, that would be an antitrust violation. It seems to me there should be something about this cost containment program.

MR. FOWLER: Well I think, again in the Royal Drug case, it tells us what the Supreme Court thinks of these alleged cost containment things on behalf of concerted activity of insurance companies. I think that case is quite clear what they think about that stuff, and we are not arguing that two wrongs make a right. But it sure seems to me, again, that this man here—If they have statistics that have been withheld, that makes liars out of about every wit- [1777] ness we had here from these major companies, because they said—and they were very clear about it—they didn't keep those statistics, that they don't know, that it was speculation. That one man said speculation; the other man said it wasn't significant, as I recall.

It bothers me.

MS. GEE: Your Honor, I think first of all Mr. Fowler is speaking about insurance company people who testified whose companies don't have the UAW business. He is mixing apples and oranges.

MR. FOWLER: I don't recall that at all.

MR. COSTILO: Your Honor, I would like to make several comments.

First of all with respect to amplify on what Ms. Gee said insofar as whether or not they do in fact contain costs, there has been testimony by witnesses that, based upon their experience, they have to contain costs and they do contain costs. Now we don't have the burden, as she had pointed out under our theory of the case, of going into how much they contain costs or what. That's the defense—First of all, if the defense raises the point and says they don't contain costs, we believe that's irrelevant when they go into that. And secondly, insofar as there is any relevancy under the rule of reason, which we challenge, that's part of their burden.

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TESTIMONY OF CHARLES NOLTING
OCTOBER 29, 1979

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[2297] Q Now, in your capacity—strike that. Well, in your capacity as investigator and presently administrator of the Dental Board, have you ever attended any IFD meetings?

A No, sir.

Q Have you ever reviewed or seen any of their minutes?

A No, sir, not to my knowledge.

Q Ever reviewed any of their newsletters? This is Indiana Federation of Dentists, now.

A Not to my knowledge, no.

Q Have you ever visited any dental insurance claims office while you've been investigator and administrator?

A No, sir.

JUDGE TEETOR: Miss Reporter, will you read that question and answer back?

(The Reporter read the record as requested.)

BY MR. COSTILO:

Q And I gather from your testimony that you are charged with the duty of making factual investigations for the Board, is that correct?

A That's right.

TESTIMONY OF RALPH D. ROHN
OCTOBER 30, 1979

* * * *

[2444] Q Do you make great use of the radiograph or x-ray in your office?

A Yes, I certainly do.

Q And since the advent of dental plans, do you—Strike that.

Have you made any kind of a study in your office since the advent of dental plans, where they request x-rays, that could help us establish what if any additional cost it would mean to your office to process these x-rays or duplicate x-rays?

A Yes, I have studied this, because in our discussions with the insurance industry they told us that this was an insignificant cost and we should happily bear this added expense because of the nice people they were. So, I did study that.

Q In your particular office, can you tell the judge what the results of your study showed, whether it would increase or decrease your costs?

A Oh, yes, it would definitely increase our costs just, if nothing else, because the materials would cost a significant amount more. Then, of course, an unexposed x-ray is valueless. To expose this, to develop it, to process it completely, including mounting it so it could be properly interpreted and these different things, considering the cost of labor—and this is not my labor, because we have an assistant doing that [2445]—I figured it would be between thirty and forty dollars a week with the volume that we have in my office; and I don't feel that we have a high volume office.

MR. COSTILO: I would like to move to strike this last question and the last answer.

In looking over the statement of Dr. Rohn's testimony here, there is no reference to any study that he made and no figures along these lines. And something as important as a study is something I would have wanted to go into, with respect to asking him in advance the methodology and the basis for it and I would have wanted to prepare on that point.

There is no reference on it.

JUDGE TEETOR: Mr. Fowler, is that right? What language do you claim covers this testimony?

MR. FOWLER: First of all, your Honor, as you stated earlier, when I referred to one of these, these were only guidelines and these are not to be specific to the point where they have to be exactly on each point of what this man might testify to.

Now he is not on here as an expert in the way you phrased our experts having had to be.

But secondly, I know there's a paragraph in here, in this thing, which states as far as economical dental care is concerned—

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TESTIMONY OF RICHARD V. JANZARUK
OCTOBER 30, 1979

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[2544] Q Did we in fact receive any guidance?

MR. COSTILO: Objection. He is being led all over the line right now, with the last three questions.

MR. FOWLER: I am sorry. Strike that.

BY MR. FOWLER:

Q Do you recall whether or not we received any guidelines in response to our request?

A We never received any guidelines.

Q Would you tell us when, if you can, Chapter Three became part of the IFD?

A That would have been 1978.

Q And where is that Chapter Three?

A That's in Fort Wayne.

Q Before I introduced that document, we were talking about proposed work rules of Chapter Two. Do you recall that?

A Yes, I do.

Q Do you recall any of the details of the proposed work rules submitted by Chapter Two?

A There were so many of them—One of them specifically had to do with nonsubmission of diagnostic aids.

Q Do you recall any of the others?

A Oh, boy. There were a number. I don't remember.

Q As President of the IFD, are you aware as to whether or not members of the IFD do submit x-rays to third-party payers under any circumstances?

[2545] A I am well aware that they do submit x-rays.

Q How have you become aware of it?

A We took a straw survey.

Q When was this done?

A About a month and a half ago.

Q Was that for this lawsuit?

A We were just interested in seeing what was going to happen.

Q Did you personally supervise the straw survey, as you called it?

A No, I did not.

Q Are you familiar with the term or concept of alternate course of treatment?

A Yes, I am.

Q How did you become familiar with that?

A It was part of the insurance contracts that came in.

Q Do you know in particular which insurance contracts you might be referring to?

A Primarily the one that affects my office would be Connecticut General and General Motors.

Q What is your understanding of the term?

A It's an alternate mode of treatment that is invoked. It is a way of giving the patient, as far as the insurance company is concerned, a less expensive but adequate amount of treatment.

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TESTIMONY OF JAMES G. PIERCE
OCTOBER 31, 1979

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[2565] A I am a consultant for Madison County.

Q How long have you had that position with them?

A Since the program started. The insurance program started in '74.

Q What are your duties, briefly, as a consultant for Connecticut General Insurance Company?

A I feel, really, that my job is to act as liaison between Connecticut General and the dentists in Anderson.

Q What do you do in your job as consultant?

A All right, if there's a problem—Is this what you are—?

Q Do you review claims for Connecticut General?

A Yes.

Q Do you check treatment?

A I do pretreatment.

Q Do you do—

MR. COSTILO: Objection. I think it is getting leading now. I think the question should really be for him to explain what he does.

JUDGE TEETOR: Well, go ahead.

BY MR. FOWLER:

Q Basically what I want you to do is to explain your entire duties as a consultant with Connecticut General.

Q All right. First, I go over pretreatment forms if [2566] there is a problem.

Should I go into how—

Q Just tell us, in detail, your duties as a consultant.

A All right.

Q How it works, the mechanics of it and so forth.

A Yesterday, for instance, I got a pretreatment review and there was a question as to the appropriateness of the treatment. The company asked me to call the dentist and get more information from him, which I did.

I also do posttreatment review. That's posttreatment review—pretreatment determination, I suppose, would be a better word. But I do posttreatment review for them. It's a contractual arrangement whereby a certain percentage of people who had dental treatment paid for by Connecticut General are picked at random and are asked to come and see me; and I check specific things, whatever treatment is requested that I check. I check that.

Q This is after it has been done.

A After it has been done, right.

Q So basically, as I understand it, you do both pretreatment, that is before the treatment has been done—

A Right.

Q —and you do posttreatment.

A Right.

Q How does a pretreatment claim get to you?

[2567] A It is sent up from Indianapolis with a routing slip, and sometimes Mr. Lambert but most often the reviewers, one of the two reviewers has a question. To illustrate, yesterday one of the ones I got the dentist was doing an inlay and the question was should there be a crown done here.

Q I am sorry, but who would ask that question?

A The reviewer.

Q Are the reviewers dentists or lay persons?

A Lay persons.

Q Now, if you will go on, you started to explain the question.

A Okay, so I called the dentist and found out what had happened to the tooth and his treatment was appropriate.

The second one I determined yesterday, the dentist was going to crown a tooth to make it more satisfactory for a partial clasp, but there was another tooth right next door to it. They were saying why crown this one when this lateral is still going to be there, and the answer was that the other tooth was going to be extracted. So, they didn't worry about it.

But this is the kind of problems that I attempt to solve.

Q And these problems are raised, you said, by questions of a reviewer.

A Yes, sir.

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[2572] A Well, I presume in the middle seventies when dental insurance first became popular.

Q In your position as consultant for Connecticut General, do you request x-rays from dentists?

A Practically never.

Q Under what circumstances would you do that?

A If I felt I need to see an x-ray, I would go to the dentist's office and look at his x-rays and talk to him personally.

Q Have you done this, on occasion, with Connecticut General?

A Once or twice. Very seldom.

Q You have been a consultant, I think you said, for several years now.

A Yes, sir.

Q Since '74.

A Yes, sir.

Q Can you tell the judge whether or not you have had problems getting the professional opinions of treating dentists?

A Judge, I have had a hundred percent cooperation. Never any question. • • •

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[2578] Q What is that effect?

A May I illustrate?

Q Surely.

A All right. Suppose a patient has teeth missing on both sides of the upper arch. The treatment of choice is two bridges. And, let's say there is just one tooth missing on each side; so, you are talking maybe fourteen, fifteen hundred dollars. A partial, a removable partial denture, which is not nearly as good treatment, is three seventy-five, four hundred. And when you are going to pay half

of one of these or the other, it's an economic thing. It certainly could have an effect on what a patient elects.

Q Do you recall back when the General Motors—Connecticut General contract became effective—I think you said in 1974—whether or not you personally had to make any changes in your office to adapt to that plan?

A I had to have more help.

Q Did you in fact hire additional help?

A Yes, sir.

Q For what purposes?

A Filling out insurance forms.

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[2601] Q Full name.

A Robert Warfield.

Q What happened after—Strike that.

Isn't it true that after you refused to submit x-rays to the company that—

A I think maybe it was Jean, his wife. It was one of the two.

Q After you refused to submit x-rays with request to this particular job that the patient went elsewhere—?

A Yes, sir.

Q And that he did not have the work done through you.

A Yes, sir.

Q Do you know what dentist he went to, to have the work done?

A No, sir.

Q But the patient changed his mind. Is that correct?

A The patient changed dentists.

Q Has that patient ever come back to you?

A No, sir.

Q Do you consider yourself to be in the leadership of IFD?

A No, sir.

Q Isn't it true that you signed a financial note as a guarantor for that organization, as one of the six guarantors on that note?

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TESTIMONY OF WILLIAM SHAFER
NOVEMBER 1, 1979

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[2681] BY MR. GRAHAM:

Q Would you state your name for the record, please?
A William G. Shafer.
Q And what is your occupation, Dr. Shafer?
A I'm a dentist.
Q And are you presently employed?
A Yes, at the Indiana University School of Dentistry.
Q And what is your capacity there?
A I'm Professor and Chairman of the Department of Oral Pathology.
Q Professor of the Department of Oral Pathology?
A Yes, sir.
Q Would you define what Oral Pathology is?
A Pathology is the study of disease, and this is specifically of oral disease.
Q And how long have you been Professor at Indiana University?
A Almost thirty years.
Q Would you describe your educational experience, please?
A I have a BS from the University of Toledo; a DDS, Dental Degree from Ohio State University; and a Masters Degree in Pathology from the University of Rochester.

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[2692] A I think that would be all to the benefit of the patient—the advantage of the patient.
Q Meaning what?
A In other words, you should utilize everything possible at your disposal.
Q Specifically what I'm asking is should a patient's treatment be affected by a diagnosis or a judgment made without having had the benefit of seeing that patient?
A By "affected," did you mean that there might be another kind of treatment?

Q Yes, sir.
A Oh, I think this would be conceivable, yes.
Q That they can be treated without having—
A Well, that the treatment could be affected—the method of treatment could be affected by whether or not you see the patient, yes. I think this could happen.
Q Is that good dental practice to allow a treatment to be affected by judgments made by persons who have not had the benefit of an oral examination?
A I think this is wrong, yes.
Q Do you believe that similarly, it is improper to have a patient's treatment affected by decisions made by persons who have not interviewed the patient or do not know the patient's history?

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[2695] Q Didn't he have two paragraphs in his letter and he asked you to give your opinion as to those two paragraphs?
A This is right.
Q Was there much other information in that letter?
A No, that was actually the two paragraphs and he asked me if I agreed with the paragraphs.
Q I show you a document in evidence as CX-549-E which contains two paragraph quotes, and I ask you if you will look at those and if these two paragraphs are essentially the paragraphs which he asked for your opinion on.
A I think those are the two essentially, I think.
Q On the basis of this letter request from Dr. Oliver, did you respond in writing to him?
A Yes, I answered him that I would be happy to serve as a witness and that—because I agreed one hundred percent with the paragraphs that he had written me.
Q Did you also say in that response to him that, "I totally agree that the submission of a single diagnostic aid to a third party would be shirking the moral/legal responsibilities for the best patient care"?
A This is right, yes, sir.

Q Did you ever see your witness summary containing essentially—the summary of the statement which you gave to Dr. Oliver in response to his letter?

A Did I ever see it?

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TESTIMONY OF DR. MYRON J. KASLE
NOVEMBER 1, 1979

[2712] DR. MYRON J. KASLE

was called as a witness, and having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. GRAHAM:

Q Would you state your name and spell your last name?

A Myrone J. Kasle. My last name is spelled K-a-s-l-e.

A Are you a doctor, Mr. Kasle?

A Yes, I am a doctor of Dental Surgery.

Q Where are you presently employed?

A Indiana University School of Dentistry.

Q In what capacity are you employed there?

A I'm Professor and Chairman of the Department of Radiology.

Q How long have you been Chairman of the Department of Radiology?

A Just about eight years now.

Q What are some of your responsibilities, Doctor?

A Well, I teach several courses in Radiology, I administer the Department, I'm in charge of all those individuals, of course, who are members of the Faculty, the Staff.

Q What is Radiology?

A Radiology is the art and science of the diagnosis interpretation of radiographs.

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[2716] Q Thank you, Doctor. What do you believe it takes to make a thorough diagnosis of a patient's oral condition?

A Well, that sounds like a four-year curriculum. Let me see if I can get it all kind of succintly here. The taking of a history of the patient, the oral physical history included, not that we take—you know, we do physical examinations but getting a history of the patient, doing a thorough clinical examination, that is inspection clinically, then takng radiographs where needed in order to substantiate any findings we may have clinically. After that, determining what other biochemical examinations may have to be made: blood tests, urinalysis, the other rest of the gamut of it.

Q Thank you. Would any one of these methods that you have indicated of diagnosis be sufficient in and of itself for a proper diagnosis?

A I don't feel it could be. I don't think any one stands alone.

Q How about a radiograph in and of itself?

A I wish it could. I tell my students that, that I [2717] wish we could be the all and end of it, but we can't. A radiograph can't stand alone, no.

Q Why not?

A Well, again, everything doesn't show on the radiograph. We just can't see all entities on a radiograph.

Q Why not? Why can't you see all things on a radiograph?

A Okay, well, we have to go back to a little understanding of the physics of production of X-rays. There are different materials that absorb X-rays more or less to a different extent, and they may show on a radiograph; bone, soft tissue, dental materials that are used for prosthesis. They all have a certain opacity to them. There are things that don't have opacity; they have radiolucency is what we call them, so really you can't make that determination just looking at a radiograph. I hope that clarified it. Again, that takes a good year to explain that to a student in the profession.

Q Are you talking about a dental student?

A Dental students.

Q How much time is spent with dental students in Radiology?

A This is a four-year curriculum. As much as they would like not to see me each semester, they do see me.

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[2728] [Pending question read back]

A I think I have already told you that I'm interested in the welfare of the patient from the health standpoint. I'm not particularly interested in whether an insurance company is going to have to pay fifty dollars or one hundred dollars for a treatment. I'm not concerned about that end of it. I'm interested in the proper taking care of that patient, and if an insurance company looks at a history, whatever it contains, and determine, "Well, that's too much for the patient. We can't afford to pay that," and that's going to be the basis upon which that patient is going to be treated, that is tantamount to malpractice.

BY MR. COSTILO:

Q Thank you. Now, with respect to the welfare of patients, which I believe you have stated is an important concern, do you have any opinion as to whether dentists should compete with each other on the basis of price, quality and service?

MR. FOWLER: There again, your Honor, this is going too far. I hate to object almost because the last answer he gave was so good, but how does this relate to direct examination.

JUDGE TEETOR: I hesitate to ask a cross-examiner to say where he's going, but I think I will in this instance.

MR. COSTILO: Very well.

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[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 13 A, Q, T, U]

CONSTITUTION AND BY-LAWS
of the
Indiana Federation of Dentists

ARTICLE I

General Provisions

Section 1. Name

This organization shall be known as the Indiana Federation of Dentists ("State Federation") and shall be composed of members and chapters affiliated with the American Federation of Physicians and Dentists in Indiana.

Section 2. Objectives:

The Indiana Federation shall represent, protect, maintain, and advance, through activities accomplished by relevant techniques which may lawfully be engaged in by a labor organization, the interests of the dentists within its jurisdiction. The objectives of this Federation shall include, but not be limited to the following:

a.) To represent dentists in all socio-economic matters, negotiations and grievances with employers, third, and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public;

b.) To seek to insure adequate compensation and proper working conditions for dentists commensurate with their training and skill and the responsibility they bear for the life and health of their fellow human beings;

c.) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of the highest quality of dental care;

d.) To associate together all dentists for their mutual benefit and protection;

e.) To unite the efforts of dentists in obtaining and preserving the individual freedom of action neceeary for the success of their professional endeavors;

f.) To study, advise, recommend, and secure the enactment of legislation in the interest of dentists;

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• • • Federation except with the express written approval of the Executive Committee of the State Federation. The State Federation shall not be responsible for any Local Chapter action, unless such action is specifically authorized by this Constitution and By-Laws or authorized or approved by the Executive Committee of the State Federation.

(c) No Local Chapter shall engage in a strike, job action, boycott or other form of economic pressure without first having received the prior written approval therefor of the State Federation.

1.) Strikes, job actions, boycotts, or other forms of economic pressure shall be determined by the Executive Committee of the State Federation. The decision of said Executive Committee shall be final, except as hereinafter provided, unless reversed by a vote of the members of the State Federation.

2.) No Local Chapter shall engage in a strike, job action, boycott, or other form of economic pressure without first having obtained the affirmative vote of a majority of the members of said

Local Chapter who shall vote in a special meeting duly called for said vote, and without the prior written consent of the Executive Committee of the State Federation. Said Local Chapters shall forthwith certify the vote of the Local Chapter membership, and said Executive Committee of the State Federation shall meet and decide whether to consent to the action requested. The decision of said Executive Committee of the State Federation shall be final unless reversed by a [illegible]e of the members of the State Federation.

3.) A Local Chapter shall conduct or join in a strike, job action, boycott, or other lawful form of economic action when so directed in writing by the Executive Committee of the State Federation. In the event that a majority of the total members of the Local Chapter vote against engagement in or participating in any such strike, job action, boycott, or other lawful form of economic action directed by the Executive Committee of the State Federation, the vote of said Local Chapter shall be certified to the Secretary of the State Federation and said Executive Committee of the State Federation shall meet and decide whether to excuse said Local Chapter from said action. The decision of the Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(d) As a preprequisite to receiving a Local Chapter Charter from the State Federation, each applying body shall, as both a condition and a covenant of its application, and for the express purpose of ?????ing the State Federation to grant a Local Chapter Charter to such applying body agree to honor completely and abide by all provisions of the Constitution and By-laws of the

State Federation as may be applicable to the Local Chapters. Each Body • • •

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• • • officer or officers, who need not be members of the State Federation, designated as such the Executive Committee. The decision of the Executive Committee or whosoever else shall have been designated to hear the appeal of the Local Chapter placed in to Trusteeship with respect to the imposition, validity, duration, and terms of the Trusteeship shall be final and binding. Pending such decision, the Trusteeship shall remain in full force and effect.

(f) The Secretary of the State Federation shall file an initial report, concerning the imposition of any Trusteeship on any Local Chapter, with the United States Department of Labor, and any other appropriate governmental agency, within thirty (30) days from the date said Trusteeship is imposed. The Secretary shall thereafter file semi-annual reports with the United States Department of Labor during the period said Trusteeship is continued.

(g) The President shall make a full report of all Trusteeships to the Convention of the State Federation.

ARTICLE X

Affiliation with American Federation of Physicians and Dentists

The State Federation, and all Local Unions shall be affiliated with the American Federation of Physicians and Dentists ("American Federation"). All members of the State Federation shall, concurrently with such membership, also be members of the American Federation. The Treasurer of the State Federation shall remit to the American Federation, on a quarterly basis, all dues, assessments, and other fees owed to the American Federa-

tion on behalf of all members. Local Chapters within this State Federation shall also remit to the Indiana Federation, on a quarterly basis, all dues, assessments, and other fees owed to the American Federation and Indiana Federation on behalf of their members. The Treasurer shall keep a record of all such transactions and shall forward a list to the American Federation specifying the names and membership numbers of the members on whose behalf said monies are being remitted.

Whensoever the StateFederation shall be entitled to choose a certain number of its members to serve as delegates, committee members, or in other functions, to and of the American Federation, the Executive Committee of the State Federation shall determine which of its members shall be appointed to such positions.

ARTICLE XI

Discipline of Indiana Federation Members

(a) The State Federation may censure, fine, suspend, or expel a member for valid cause including, but not limited to, the following:

1.) Failure to conform to the Constitution and Bylaws of the Indiana Federation;

2.) Dishonesty in dealing with fellow members while acting as a representative of the State Federation;

3.) Conviction of a felony or other criminal offense which would tend to bring discredit upon the State Federation;

4.) Dual unionism (Joining another union of physicians and dentists when the State Federation claims jurisdiction in the same area;

5.) Preferring false charges against another member; or

6.) Any action detrimental to the welfare of this organization or acts which would serve to bring disrepute upon this organization, its superior body, or any subordinate body hereof.

(b) Charges against any member may be filed with the Secretary, in writing by any member of the Executive Committee ("charging member"). A member so charged ("charged member") shall have the right to written notice thereof and a fair and impartial hearing thereon before the Executive Committee or such other committee as the President may, or may have established for the purpose of presiding at such a hearing. In the event the President is an interested party, either as a charged member or a charging member, then the President shall not participate and the Vice President shall perform his duties in his stead. In the event both the President and the Vice President are either charging members or charged members, then they shall be disqualified and the Treasurer shall perform the duties of the President. If the President, Vice President, and Treasurer are charging members or charged members, then they shall be disqualified and the Secretary shall perform the duties of the President. If all of the Constitutional officers are either charging members or charged members, then the remaining members of the Executive Committee shall perform the duties of the President provided hereunder. No charges shall be accepted against the entire Executive Committee and the sole remedy insofar as charges against the entire Executive Committee is concerned shall be by way of recall in the manner provided in this Constitution. The charged member shall be served with charges in affidavit form in person or by registered mail, and all relevant documentation, depositions, affidavits, lists of witnesses, and any and all other forms of available evidence bearing on the matter under consideration shall be filed with the Secretary of the State Federation by both the charging member and the charged member,

and such shall be made reasonaably available to all such parties concerned for examination and copying. A public hearings on the charges shall be held within sixty (60) days from the date on which the charges are served on the charged member, and the charged member shall have the right to counsel, present at such hearing, by an attorney of his choice or by a member of the State Federation. The charged member shall have the right to cross examine witnesses who appear or testify against him, to present witnesses in his defense and to refute the charges; the hearing shall not, however, be required to follow common law or statutory rules of evidence as may be applied in Indiana or Federal • • •

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[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 14 A, Q, S]

CONSTITUTION AND BYLAWS OF INDIANA FEDERATION OF DENTISTS, CHAPTER #1

ARTICLE I

General Provisions

Section 1. Name

This organization shall be known as the Indiana Federation of Dentists, Chapter No. 1 ("The Chapter") and shall be composed of members affiliated with the Indiana Federation of Dentists and the American Federation of Physicians and Dentists located in the practice areas of Madison County, Indiana, and the practice areas of Daleville and Middletown, Indiana.

Section 2. Objectives:

The Indiana Federation, Chapter No.1. shall represent, protect, maintain and advance, through activities accomplished by relevant techniques which may lawfully be engaged in by a labor organization, the interests of the dentists within its jurisdiction. The objectives of this Chapter shall include, but not be limited to the following:

(a) To represent dentists in all socio-economic matters, negotiations and grievances with employers, third and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public,

(b) To seek to insure adequate compensation and proper working conditions for dentists commensur-

ate with their training and skill and the responsibility they bear for the life and health of their fellow human beings,

(c) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of the highest quality of dental care,

(d) To associate together all dentists for their mutual benefit and protection,

(e) To unite the efforts of dentists in obtaining and preserving the individual freedom of action necessary for the success of their professional endeavors,

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Section 3. Parliamentary Authority

The parliamentary provisions of the Federal Labor-Management Reporting and Disclosure Act of 1959, as amended, pertaining to unions, as well as any other applicable Federal and Indiana statutes, shall be followed in all activities of the Chapter when required by law.

ARTICLE IX

Relationship with the Indiana Federation and the American Federation

(a) The Chapter shall honor completely and abide by all provisions of the Constitution and Bylaws of the Indiana Federation and the American Federation of Physicians and Dentists as may be applicable to Local Chapters thereof. The Chapter shall adopt and maintain this Constitution and Bylaws consistent with, and in conformity with, the Constitution of the Indiana Federation of Dentists and the American Federation of Physicians and Dentists. The Chapter shall be responsible for those affairs and matters which concern dentists within the Chapter's jurisdiction. The Chapter shall not enter into any collective bargaining agreement except with the authorization and approval of the Indiana Federation.

(b) The Chapter shall not incorporate, nor shall the Chapter make any contract or incur any liability on behalf of the Indiana Federation or the American Federation except with the express written approval of the Executive Committee of the Indiana Federation. The Indiana Federation and the American Federation shall not be responsible for any Chapter action, unless such action is specifically authorized by the Constitution and Bylaws or authorized or approved by the Executive Committee of the Indiana Federation or the American Federation.

(c) The Chapter shall not engage in a strike, job action, boycott or other form of economic pressure without first having received the prior written approval therefor of the State Federation.

(1) The Chapter shall not engage in a strike, job action, boycott, or other form of economic pressure without first having obtained the affirmative vote of a majority of the members of said Chapter who shall vote in a special meeting duly called for said vote, and without the prior consent of the Executive Committee of the State Federation. Said Chapter shall certify to the Secretary of the State Federation the results of the vote of the Chapter membership, and said Executive Committee of the State Federation shall meet and decide whether to consent to the action requested. The decision of said Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(2) A Chapter shall conduct or join in a strike, job action, boycott, or other lawful form of economic action when so • • •

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• • • Physicians and Dentists ("American Federation"). All members of the Chapter shall, concurrently with such membership, also be members of the American Federation.

ARTICLE XI

Discipline of Chapter Members

(a) The Chapter may censure, fine, suspend, or expel a member for valid cause including, but not limited to, the following:

(1) Failure to conform to the Constitution and By-laws of the Chapter;

(2) Dishonesty in dealing with fellow members while acting as a representative of the Chapter;

(3) Conviction of a felony or other criminal offense which would tend to bring discredit upon the Chapter;

(4) Dual unionism (joining another union of physicians and dentists when the State Federation claims jurisdiction in the same area);

(5) Preferring false charges against another member; or

(6) Any action detrimental to the welfare of this organization or acts which would serve to bring disreput upon this organization, its superior body, or any subordinate body hereof.

(b) Charges against any member may be filed with the Secretary, in writing, by any member of the Executive Committee ("charging member"). A member so charged ("charged member") shall have the right to written notice thereof and a fair and impartial hearing thereon before the Executive Committee or such other committee as the President may, or may have, established for the purpose of presiding at such a hearing. In the event the

President is an interested party, either as a charged member or a charging member, then the President shall not participate and the Vice President shall perform his duties in his stead. In the event both the President and the Vice President are either charging members or charged members, then they shall be disqualified and the Treasurer shall perform the duties of the President. If the President, Vice President, and Treasurer are charging members or charged members, then they shall be disqualified and the Secretary shall perform the duties of the President. If all of the Constitutional officers are either charging members or charged members, then the remaining members of the Executive Committee shall perform the duties of the President provided hereunder. No charges shall be accepted against the entire Executive Committee and the sole remedy insofar as charge against the entire Executive Committee is concerned shall be by way of recall in the manner provided in this Constitution. The charged member shall be served with charges in affidavit form in person or • • •

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[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 15 A, P, Q]

CONSTITUTION AND BYLAWS OF INDIANA FEDERATION OF DENTISTS, CHAPTER#2

ARTICLE I

General Provisions

Section 1. Name

This organization shall be known as the Indiana Federation of Dentists, Chapter No. 2 ("The Chapter") and shall be composed of members affiliated with the Indiana Federation of Dentists and the American Federation of Physicians and Dentists located in the practice areas of Tippecanoe County, Clinton County, White County and Carroll County.

Section 2. Objectives

The Indiana Federation, Chapter No.2 shall represent, protect, maintain and advance, through activities accomplished by relevant techniques which may lawfully be engaged in by a labor organization, the interests of the dentists within its jurisdiction.

The objectives of this Chapter shall include, but not be limited to the following:

(a) To represent dentists in all socio-economic matters, negotiations and grievances with employers, third and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public,

(b) To seek to insure adequate compensation and proper working conditions for dentists commensurate with their training and skill and the responsibility they bear for the life and health of their fellow human beings,

(c) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of highest quality of dental care,

(d) To associate together all dentists for their mutual benefit and protection,

(e) To unit the efforts of dentists in achieving and preserving the individual freed of action necessary for the effectiveness of their professional endeavors, * * *

* * * Federation or the American Federation.

(c) The Chapter shall not engage in a strike, job action, boycott or other orm of economic pressure without first having received the prior written approval therefor of the State Federation.

(1) The Chapter shall not engage in a strike, job action, boycott, or other form of economic pressure without first having obtained the affirmative vote of a majority of the members of said Chapter who shall vote in a special meeting duly called for said vote, and without the prior consent of the Executive Committee of the State Federation. Said Chapter shall certify to the Secretary of the State Federation the results of the vote of the Chapter membership, and said Executive Committee of the State Federation shall meet and decide whether to consent to the action requested. The decision of the said Executive Committee of the State Federation shall be final unless

reversed by a vote of the members of the State Federation.

(2) A Chapter shall conduct or join in a strike, job action, boycott, or other lawful form of economic action when so directed in writing by the Executive Committee of the State Federation. In the event that a majority of the total members of the Chapter vote against engagement in or participating in any such strike, job action, boycott, or other lawful form of economic action directed by the Executive Committee of the State Federation, the vote of said Chapter shall be certified to the Secretary of the State Federation and said Executive Committee of the State Federation shall meet and decide whether to excuse said Chapter from said action. The decision of the Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(d) No chapter shall enter into any collective bargaining agreement except with the authorization and approval of the State Federation.

(1) The State Executive Committee shall authorize and approve any collective bargaining agreement. The decision of said Executive Committee shall be final, except as hereinafter provided, unless reversed by a vote of the members of the State Federation.

(2) The Chapter shall not enter into any collective bargaining agreement without first having obtained the affirmative vote of a majority of the members of the Chapter who shall vote in a Special Meeting duly called for said vote, and without the prior written authorization and approval of the Executive Committee of the State Federation. The Chapter shall forthwith certify to the Secretary of the State Federation the results of the vote of the Chapter membership and said Executive Committee of the State Federation shall meet and decide whether to authorize and

approve any collective bargaining agreement. The decision of said Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(3) The Chapter shall approve and ratify any collective bargaining agreement when so directed in writing by the Executive Committee of the State Federation. In the event that a majority of the total members of the Chapter vote against approval or ratification of any collective bargaining agreement as directed by said Executive Committee of the State Federation, the vote of the Chapter shall be certified to the Secretary of the State Federation and said Executive Committee of the State Federation shall meet and decide whether to excuse the Chapter. The decision of the Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

ARTICLE X

Affiliation with the American Federation of Physicians and Dentists

The Chapter shall be affiliated with the American Federation of Physicians and Dentists (American Federation). All members of the Chapter shall, concurrently with such membership, also be members of the American Federation.

ARTICLE XI

Discipline of the Chapter Members

(a) The Chapter may censure, fine, suspend, or expel a member for valid cause including, but not limited to, the following:

(1) Failure to conform to the Constitution and By-laws of the Chapter;

(2) Dishonesty in dealing with fellow members while acting as a representative of the Chapter.

(3) Conviction of a felony or other criminal offense which would tend to bring discredit upon the Chapter;

(4) Dual unionism (joining another union of physicians and dentists) when the State Federation claims jurisdiction in the same area;

(5) Preferring false charges against another member; or

(6) Any action detrimental to the welfare of this organization of acts which would serve to bring disrepute upon this organization, its superior body, or any subordinate body hereof.

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[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 16 A, Q, R, S]

CONSTITUTION AND BYLAWS OF INDIANA FEDERATION OF DENTISTS, CHAPTER #III

ARTICLE I

General Provisions

Section 1. Name

This organization shall be known as the Indiana Federation of Dentists, Chapter No. III ("The Chapter") and shall be composed of members affiliated with the Indiana Federation of Dentists and the American Federation of Physicians and Dentists located in Allen County, Indiana and the contiguous Dental practice areas.

Section 2. Objectives

The Indiana Federation, Chapter No. III shall represent, protect, maintain and advance, through activities accomplished by relevant techniques which may lawfully be engaged in by a labor organization, the interests of the dentists within its jurisdiction. The objectives of this Chapter shall include, but not be limited to the following:

(a) To represent dentists in all socio-economic matters, negotiations and grievances with employers, third and fourth parties or any group that is involved in financing or delivery of dental care. The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public,

(b) To seek to insure adequate compensation and proper working conditions for dentists commen-

surate with their training and skill and the responsibility they bear for the life and health of their fellow human beings,

(c) The establishment or approval of appropriate utilization review or peer review procedures which do not interfere with the doctor-patient relationship and the maintenance of the highest quality of dental care,

(d) To associate together all dentists for their mutual benefit and protection,

(e) To unite the efforts of dentists in obtaining and preserving the individual freedom of action necessary for the success of their professional endeavors * * *

* * * *

* * * shall be responsible for those affairs and matters which concern dentists within the Chapter s jurisdiction. The Chapter shall not enter into any collective bargaining agreement except with the authorization and approval of the Indiana Federation.

(b) The Chapter shall not incorporate, nor shall the Chapter make any contract or incur any liability on behalf of the Indiana Federation or the American Federation except with the express written approval of the Executive Committee of the Indiana Federation. The Indiana Federation and the American Federation shall not be responsible for any Chapter action, unless such action is specifically authorized by the Constitution and Bylaws or authorized or approved by the Executive Committee of the Indiana Federation or the American Federation.

(c) The Chapter shall not engage in a strike, job action, boycott or other form of economic pressure without first having received the prior written approval therefor of the State Federation.

(1) The Chapter shall not engage in a strike, job action, boycott, or other form of economic pressure without first having obtained the affirmative vote of a majority of the members of said Chapter who shall vote in a special meeting duly called for said vote, and without the prior consent of the Executive Committee of the State Federation. Said Chapter shall certify to the Secretary of the State Federation the results of the vote of the Chapter membership, and said Executive Committee of the State Federation shall meet and decide whether to consent to the action requested. The decision of said Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(2) A Chapter shall conduct or join in a strike, job action, boycott, or other lawful form of economic action when so directed in writing by the Executive Committee of the State Federation. In the event that a majority of the total members of the Chapter vote against engagement in or participating in any such strike, job action, boycott, or other lawful form of economic action directed by the Executive Committee of the State Federation, the vote of said Chapter shall be certified to the Secretary of the State Federation and said Executive Committee of the State Federation shall meet and decide whether to excuse said Chapter from said action. The decision of the Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(d) No Chapter shall enter into any collective bargaining agreement except with the authorization and approval of the State Federation.

(1) The State Executive Committee shall authorize and approve any collective bargaining agreement. The decision of said Executive Committee shall be

final, except as hereinafter provided, unless reversed by a vote of the members of the State Federation.

(2) The Chapter shall not enter into any collective bargaining agreement without first having obtained the affirmative vote of a majority of the members of the Chapter who shall vote in a special meeting duly called for said vote, and without the prior written authorization and approval of the Executive Committee of the State Federation. The Chapter shall forthwith certify to the Secretary of the State Federation the results of the vote of the Chapter membership and said Executive Committee of the State Federation shall meet and decide whether to authorize and approve any collective bargaining agreement. The decision of said Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

(3) The Chapter shall approve and ratify any collective bargaining agreement when so directed in writing by the Executive Committee of the State Federation. In the event that a majority of the total members of the Chapter vote against approval or ratification of any collective bargaining agreement as directed by said Executive Committee of the State Federation, the vote of the Chapter shall be certified to the Secretary of the State Federation and said Executive Committee of the State Federation shall meet and decide whether to excuse the Chapter. The decision of the Executive Committee of the State Federation shall be final unless reversed by a vote of the members of the State Federation.

ARTICLE X

Affiliation with the American Federation of Physicians and Dentists

The Chapter shall be affiliated with the American Federation of Physicians and Dentists (American Federation). All members of the Chapter shall, concurrently with such membership, also be members of the American Federation.

ARTICLE XI

Discipline of Chapter Members

(a) The Chapter may censure, fine, suspend, or expel a member for valid cause including, but not limited to, the following:

(1) Failure to conform to the Constitution and By-laws of the Chapter;

(2) Dishonesty in dealing with fellow members while acting as a representative of the Chapter;

(3) Conviction of a felony or other criminal offense which would tend to bring discredit upon the Chapter;

(4) Dual unionism (joining another union of physicians and dentists when the State Federation claims jurisdiction in the same area;

(5) Preferring false charges against another member; or

(6) Any action detrimental to the welfare of this organization or acts which would serve to bring disrepute upon this organization, its superior body, or any subordinate body hereof.

(b) Charges against any member amy be filed with the Secretary, in writing, by any member of the Executive Committee ("charging member"). A member so charged (charged member) shall have the right to written notice thereof and a fair and impartial hearing thereon before the Executive Committee or such other committee as the President may, or may have, established for the purpose of presiding at such a hearing. In the event the President is an interested party, either as a charged member or a charging member, then the President shall not partici-

pate and the Vice-President shall perform his duties in his stead. In the event both the President and the Vice President are either charging members or charged members, then they shall be disqualified and the Treasurer shall perform the duties of the President. If all of the Constitutional officers are either charging members or charged members, then the remaining members of the Executive Committee shall perform the duties of the President provided hereunder. No charges shall be accepted against the entire Executive Committee and the sole remedy insofar as charges against the entire Executive Committee is concerned shall be by way of recall in the manner provided in this Constitution. The charged member shall be served, with charges in affidavit form in person or by registered mail, and all relevant documentation, depositions, affidavits, lists of witnesses, and any and all other forms of available evidence bearing on the matter under consideration shall be filed with the S ecretary of the Chapter by both the charging member and the charged member, and such shall be made reasonably available to all such parties concerned for examination and copying. A public hearing on the charges shall be held within sixty (60) days from the date on which the charges are served on the charged member, and the charged member shall have the right to counsel present at such hearing, by an attorney of his choice or by a member of the State Federation. The charged member shall have the right to cross-examine witnesses who appear or testify against him, to present witnesses in his defense, and to refute the charges; the hearing shall not, however, be required to follow common law or statutory rules of evidence as may be applied in Indiana or Federal courts or administrative tribunals. The charged member shall be provided with a decision on the matter, in writing, within a reasonable time after the completion of the hearing, not to exceed thirty (30) days following the date of completion of the hearing. The charged member shall have the right to appeal the decision of any such hearing

and judicial body to the general membership at its next meeting or at a Special Meeting duly called for such purpose. At any such meeting, the membership may sustain, reduce or overrule the decision rendered or any penalties assessed, but may not increase such penalties.

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[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 22 A, B]

MINUTES OF THE FIRST MEETING
OF ORGANIZERS

and

FIRST MEETING OF THE
EXECUTIVE COMMITTEE

of

THE INDIANA FEDERATION OF DENTISTS

Madison County Dentists met on Tuesday, August 24, 1976, at 7:00 o'clock p.m., at Lee Auditorium in Alexandria, Indiana. Present were 47 members of said Association. Dr. Victor Clevenger was chairman of the meeting and Dr. David G. Yater was secretary of the meeting.

The chairman called the meeting to order and introduced Dr. C. Dan Rohn. Dr. Rohn presented the positive and negative aspects of unionisms.

Dr. David B. McClure was introduced and presented the proposal of a special committee from the dentists of Madison County, Indiana, to form a union affiliated with the American Federation of Physicians and Dentists.

The meeting was then opened to a question and answer session from those present. After due discussion Dr. J.G. Pierce moved as follows:

> That the Association form a State Federation of Dentists and affiliate with the American Federation of Physicians and Dentists and that said action be taken if supported by a two-thirds (⅔) vote of the persons present.

Dr. Jerome A. Follmar seconded the motion.

After further and lengthy discussion, Dr. Paul R. Van Dorn called for the question, and his call was seconded by

Dr. John T. Boyle. The call for the question carried by more than a two-thirds (⅔) vote of those present. The motion was carried by a vote of 40 ayes and 7 nays.

The chairman then stated that the next order of business would be to designate and elect the officers and members of the first executive committee for the labor organization, to determine upon and execute a constitution and by-laws of the organization, and to do all other things necessary to form the labor organization.

Dr. Dean E. Hoppes moved that the following persons be elected officers and members of the first executive committee of the Indiana Federation of Dentists and serve until their successors shall be duly elected, to wit:

> Dr. David B. McClure, President and member of the Executive Committee;
>
> Dr. C. Dan Rohn, Vice President and member of the Executive Committee;
>
> Dr. David G. Yater, Secretary and member of the Executive Committee;
>
> Dr. David C. Steele, Treasurer and member of the Executive Committee;
>
> Dr. Elmer R. Moreillon, Member of the Executive Committee;
>
> Dr. J. G. Pierce, member of the Executive Committee;
>
> Dr. James H. Worster, member of the Executive Committee; and
>
> Dr. Victor Clevenger, member of the Executive Committee.

Said motion was duly seconded by Dr. John T. Boyle. Said persons unanimously selected to their respective offices and as members of said first executive committee.

Dr. David B. McClure then continued to preside over the meeting.

A discussion was held concerning the proposed dues structure of the labor organization. Dr. Paul R. Van Dorn moved that the membership approve a dues structure of Two Hundred Dollars ($200.00) per year for the Indiana Federation of Dentists, Three Hundred Dollars ($300.00) per year for any local affiliates, and a One Hundred Dollars ($100.00) application fee to be paid to the Indiana Federation of Dentists. Dr. Tom King seconded the motion. Said motion carried without opposition.

Dr. David B. McClure then suggested that the executive committee should meet and prepare a constitution and by-laws to be presented at a later meeting of the members to be held September 9, 1976, at 7:00 o'clock p.m. at Lee Auditorium.

Upon motion to adjourn made by Dr. Joseph Bigelow and seconded by Dr. John T. Boyle, said meeting was adjourned.

Respectfully submitted:

/s/ Dr. David G. Yater
DR. DAVID G. YATER
Secretary

APPROVED:

/s/ Dr. David B. McClure
DR. DAVID B. MCCLURE
President

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT 33 H]

Form 1024 (Rev. 10-75)

Schedule C Organizations described in sections 501 (c) (5) (Labor, agricultural or horticultural organizations) and 501 (c) (6) (Business leagues, chambers of commerce, etc.)

1 Describe any services you perform or plan to perform for members or others. These services include furnishing credit reports, collecting accounts, inspecting products, conducting advertising, purchasing or selling merchandise or other similar undertakings. (If the description of the services is contained in Part III (pages 2, 3, and 4), just make reference below to the page and item number.) To negotiate contracts or terms in contracts for dental services and working conditions for dentists. To conduct educational activities for members.To represent dentists in all socio-economic matters, negotiations and grievances with other parties. To promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public. To study, advise, recommend, and secure the enactment of legislation in the interests of dentists.

2 Submit representative copies of any publications (newsletters, trade journals, yearbooks, membership directories, etc.) distributed to members or other interested parties.

3 Business leagues, chambers of commerce, etc., only.—If you receive income from a trade show or rental of display space at your meetings or conventions, furnish full details and attach representative copies of your contracts.
N/A

4 Labor organizations only.—If you are formed pursuant to a collective bargaining agreement, attach a copy of the latest agreement.

Schedule D Organizations described in section 501 (c) (7) (Social clubs)

1 Have you entered or do you plan to enter into any contract or agreement for the management or operation of your property and/or activities, such as restaurants, pro shops, lodges, etc? ☐ Yes ☐ No
If "Yes," attach a copy of the contract or agreement. If one has not been drawn up as yet, explain your plans below.

2 Do you solicit or plan to solicit public patronage of your facilities by advertisement or otherwise? ☐ Yes ☐ No
If "Yes," attach sample copies of such advertisements or other solicitations. If you have none as yet, explain your plans below.

3(a) Are nonmembers other than guests of members permitted or will they be permitted to use the club facilities or participate in or attend any functions or activities conducted by the organization? ☐ Yes ☐ No
If "Yes," describe the functions or activities in which there has been or will be nonmember participation or admittance. (Submit a copy of your house rules, if any.)

(b) State the amount of nonmember income included in lines 3 and 4 of part IV, page 5 ►

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 99 F, G, I]

I.D.A. POLICY REGARDING GROUP DENTAL CARE **

Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care

1. The plan should be developed, maintained and promoted to the public with the advice of authorized representatives of the state dental society.

*2. The plan should encourage the maintenance of a high standard of dental treatment.

3. The plan must not involve the dentist as a contractual party nor shall the plan publish a list of participating dentists.

*4. The promotional standards under which the prepayment plan is devolped must meet the requirements of the "Principles of Ethics" of the American Dental Association and the Code of Ethics of the state and local dental societies involved.

*5. The limitations of benefits available under the plan must be clearly described.

6. The areas of responsibility involved in the administration of the plan must be recognized and properly evaluated.

a. The administration of the professional phases of the plan should be entirely within the control of

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* Principles Adopted and Revised by the A.D.A. *1955* Transactions, October 17-20, p. 216; *1956* Transactions, October 1-4, p. 203 and *1957* Transactions, November 4-7, p. 389.

** I.D.A. Policy Regarding Group Dental Care—Adopted I.D.A. House of Delegates, May 22, *1962* and Amended I.D.A. House of Delegates, *1965, 1966, 1970, 1972, 1973, 1974,* and *1975.*

professional personnel. Professional standards and treatment should not be controlled by non-dental administrators.

b. The method of authorization of dental health care under prepayment plans should be limited to determining the eligibility of the patient and extent of liability of the plan and should prevent any interference with the dentist-patient relationship or with the judgment and decision of the dentist. The plan must not *require* the dentist to submit either pre or post-operative radiographs to a third party.

c. The submission of a total estimate is acceptable, *if requested by the patient.*

7. The determination of costs of dental care should be based upon accurate, current statistical data which reflect fees in the area in which the plan operates. Table of allowances or indemnity schedules should be developed with the advice and assistance of the dental society in order that they may (1) assure high standards of treatment in providing benefits under the plan and (2) be adjusted in accordance with major changes in the economic level at reasonable intervals. These schedules do not necessarily represent the dentist's full fee. Patients are responsible for the difference.

8. The patient must have freedom to choose the dentist to whom he may wish to apply for treatment. Similarly, the dentist must have the right to accept or not accept patients who apply for treatment.

*9. The financial reserves of the plan should be adequate to assure continuity of the program.

10. All licensed dentists must be eligible to participate.

*11. The plan should make adequate provisions for the adjustment of any complaints that may arise in the dentist-patient relationship.

12. The plan should include a sound program of dental health education for its beneficiaries especially with regard to preventive dentistry and patient responsibility and should encourage the inclusion of an incentive utilization factor.

13. Hospitalization shall not be a prerequisite for paying dental claims unless hospitalization of the patient is deemed necessary by the attending physician and/or dentist.

14. All licensed practitioners are eligible and permitted to provide those services which they can capably and legally render under Indiana law without restraints from third parties, and the level of payment for services whether performed by a dental specialist or general practitioner should reflect the usual fee of the provider and the reasonable fee for demonstrated extraordinary services.

INDIANA DENTAL ASSOCIATION POLICY STATEMENTS

Alternate Treatment Concept

The Indiana Dental Association is opposed, in the interest of providing the best possible level of dental care for the patient, to the inclusion of the "alternate mode of treatment" or "optional course of treatment" concept or any other mechanism that might directly or indirectly influence the patient in his choice of the attending dentist's treatment in prepayment dental plans. (May 1976)

Dental Insurance Consultants

A list of dental consultant nominees may be supplied to insurance carriers by the I.D.A. if the following criteria are met by the carrier.

1. The consultant nominees shall be licensed Indiana dentists.
2. The consultant will work within the I.D.A. Principles of Acceptability and
3. The consultant nominees shall be reviewed on a yearly basis by the I.D.A. Council on Dental Care Programs.

The method of selecting the dental consultant nominees shall be—

1. The Executive Committee of the district dental society involved; in consultation with the Component I.D.A. Council on Dental Care Programs representative(s), shall nominate a minimum of three (3) nominees for each consultant requested.
2. The dental consultant nominees shall be submitted to the I.D.A. Central Office.

3. The Chairman of the I.D.A. Council on Dental Care Programs shall submit the nominees to the carrier.

In addition, when predetermination of benefits involving a dental specialist cannot be resolved by the dentist consultant, or if there is disagreement between the dental specialist and the dental consultant, then the dental consultant should seek the advice of a qualified dental consultant specialist of the appropriate specialty group from a list provided to the I.D.A. by the recognized Indiana dental specialty groups to be utilized in the predetermination of benefits. (May 1975)

Reimbursement

a. The Indiana Dental Association approves and supports the Bill Payer concept as an alternate method of providing reimbursement to patients for dental care benefits. (May 1976)

b. The fiscal and health interests of patients are best served by the existence of an economic climate within which a dentist and his patient are able freely to arrive at mutual agreement with respect to fees for services.

   Attempts to interfere with this relationship will be vigorously opposed by the profession. These statements shall be included in all I.D.A. policy and publications involving fee reimbursement. (May 1976)

c. A preferred reimbursement mechanism for insurance programs is the table of allowance and indemnity type schedules in place of the U and R fee concept.

   All spokespersons for the Association shall promote these concepts in their consultation with

management, labor and government organizations. (May 1976)

Freedom of Choice

To assure the patient's freedom of choice of dentist, the Indiana Dental Association considers it improper and unacceptable to the dental profession any time a third party limits reimbursement in any way due to a dentist not signing a contractual agreement. (May 1976)

Office Audits

The Indiana Dental Association vigorously opposes the concept of "office audit". (May 1976)

Post-Treatment Review

The Indiana Dental Association is opposed to Post-Treatment Review when it is not in conjunction with the Association's peer review mechanism. (May 1976)

[EMBLEM]

EST. 1858

TO ALL MY PATIENTS

I invite you to discuss frankly any questions regarding dental service or fees.

The best dental service is based on a friendly, mutual understanding between doctor and patient.

To insure this understanding, our policy toward dental insurance is as follows:

1) If you have insurance or a union contract that will take care of all or part of the charge for completed dental treatment or surgery, we will be glad to provide you with a dental claim form which you may file with your insurance carrier or union office so that you can be reimbursed for the payment you make here.
2) In case payment is later made to the doctor by your insurance company, the check or payment will be mailed to you, providing all fees for dental services have been paid.
3) Your insurance company or union has an obligation to you, none to the doctor. You pay them for this protection. Their obligation is stated in your policy or contract. Therefore, if obligated, they pay you to the extent of their liability.
4) I will be happy to provide you with a statement on an IDA-ADA-HIC approved claim form stating the services and charges to be rendered, providing you request this prior to the start of your treatment. This will permit you to determine the extent of your insurance carrier's coverage before the services are rendered.
5) Dental radiographs are a part of the dentist's legal health records. They are available for valid review by a qualified representative(s) of your insurance com-

pany in this office. Radiographs will not be submitted to third parties for their use in determination of benefits (e.g., least expensive adequate procedure, or optional course of treatment) because a determination of an adequate treatment plan can only be made after a knowledge of the following:

A. Complete patient evaluation.

B. Radiographs

C. Additional diagnostic procedures as required.

6) Your obligations are:

a) To certify to the insurance company or union that your treatment was completed.

b) To understand that you are financially responsible to the doctor for the services rendered.

Thank you

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 108 C]

2. *Blue Shield should use the right-hand column on the I.D.A. standard dental claim form for the intended purpose of the pre-certification form.*

Passed

Dr. Ricci moved and Dr. Fontaine seconded a motion that a memo be sent to all I.D.A. members explaining the advantages of using the I.D.A. standard dental claim form only and the disadvantages of using insurance companies' pre-certification forms such as proposed by Blue Cross-Blue Shield and in use by Metropolitan Insurance Company.

Passed

III. *United Auto Workers Follow Up*

Mr. L. Beckwith, Baker and Daniels met with the Council to report on the firm's investigation of legal action relative to the radiograph problem in dental insurance plans. He explained that they had not completed their investigation and final recommendations; however, he could give the Council their findings etc. to date.

He noted that the Association's position in this matter (i.e., not party to a contract) makes it difficult to find a basis for a suit. However, the attorneys had not given up on this.

Tentative Recommendations

1. File a formal complaint with the Indiana Insurance Commissioner—point out that insurance company requests for x-rays is unjust etc.

   The problem with this is that a podiatry case with a similar question did not receive a favorable decision. The insurance commissioner may say he has no authority in such or may not take any action.

2. File an injunction. Seek a cease and desist order preventing insurance companies from asking for x-rays. At the same time seek declaratory judgment of who has the right to the radiographs.

   The insurance companies may not defend in this saying they have no interest.

3. Suit. Join with a patient to file suit against an insurance company, or have a patient or insurance company sue the dental association.

   There is a question of legal ethics and law regarding such actions as these. Cases cannot be manufactured. This is a point to be considered, but could probably be worked out.

There was considerable discussion as to what course of action the Association should take with regard to legal steps. Several pointed out that for months, years we have been discussing the radiograph problem and members are calling for action. It is time some action was taken.

The Council reviewed what follow up has been done by the Task Force on Dental Care Programs since the May meeting with the insurance commissioner. Noting that a meeting will be scheduled with the Commissioner in late August or early September. Depending on the outcome of this meeting, there was a definite feeling among the Council members for legal action.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 145 A, C]

IDA

INDIANA DENTAL ASSOCIATION

a constituent of the american dental association
402 Jefferson Building, One Virginia Avenue
Indianapolis, Indiana 46204
317/634-2610

February 27, 1975

To: IDA Officers and Trustees, Annual Session Directors and Dr. Phillips, ADA Trustee

From: G. E. Coons

Subject: Results of Post Card Survey on X-rays

The Board of Trustees, on January 19, asked the IDA Central Office to conduct a post card survey of IDA members regarding their thoughts and actions on x-rays and dental insurance programs.

The results of the survey have been tabulated (including written comments) and are enclosed with this memo. This information has been sent to only those listed above. We will keep it this way until the Board gives us further direction on or before April 19.

The questions asked by the survey were as follows:

1. Are you in private practice in Indiana? (If "No" you need not answer the other questions. Please return the card.)
2. Are you receiving requests from third parties (insurance companies) for x-rays?
3. Are you presently sending x-rays to third parties?
4. If the answers to questions 2 and 3 are "No", would you send x-rays if requested?

Note that question No. 4 states that, "If the answers to questions 2 and 3 are "No", would you . . . ."? About 40-50% of questions 2 and 3 were answered "Yes" and "No" respectively rather than both "No". When questions were answered this way, we did not count an answer to No. 4. If we had, the results would have been different than reported on the enclosed data sheet. The answers were 109 "Yes" and 845 "No".

In any event the results show that out of 2,000 surveys mailed we had a 67% return (1342). Of those cards returned 95% were from private practice dentists. Of these 1268, there were 1238 who answered question No. 3 and 89% of them said they were *not* submitting x-rays to third parties.

Results of post card survey on X-rays by Component Societies Jan. 28, 1975	1. Are you in private practice in Indiana?		2. Are you receiving requests from third parties for x-rays?		3. Are you presently sending x-rays to third parties?		4. If the answers to questions 2 & 3 are NO, would you send x-rays if requested?		TOTAL RESPONSES
Component Soc.	yes	no	yes	no	yes	no	yes	no	
Ben Hur	15	0	4	11	0	15	0	10	15
East Central	83	4	34	51	1	82	0	49	87
Eastern Ind.	26	2	18	8	1	25	1	7	28
First District	105	3	61	44	4	99	3	39	108
Greene District	16	1	12	5	1	15	0	5	17
Indianapolis Dist.	318	34	217	93	55	253	8	74	352
Isaac Knapp	105	4	83	22	4	101	1	20	109
North Central	128	6	63	62	4	122	5	54	134
Northwest	169	11	134	30	31	133	7	20	180
South Central	84	1	53	32	14	69	0	28	85
Southeastern	38	2	23	13	4	32	0	12	40
Wabash Valley	62	3	42	18	7	53	0	18	65
West Central	63	1	36	27	4	59	2	24	64
Western Indiana	56	2	31	22	3	47	2	18	58
Grand Total	1268	74	811	438	133	1105	29	378	1342

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 157 A]

EAST CENTRAL DENTAL SOCIETY

AUGUST 15, 1974

The East Central Dental Society met at the Anderson Country Club on Thursday, August 15, 1974. After an afternoon of golf, President David C. Lind called the meeting to order at 8:20 P.M. Thirty-seven members and guests were present. Guests in attendance were Pete Strugar, Fort Wayne Dental Depot; Mike Tuttle, T.M. Crutcher Dental Depot; and Louis Rock, Lafayette Dental Laboratory.

Secretary-Treasurer Paul Risk read the minutes of the April 24, 1974 meeting which were approved as read. New members, Dr. Brank DeBruhl, Middletown; Dr. Gary Smith, Anderson; and Dr. Joe Barnett, Elwood; were introduced to the society.

Golf outing Chairman, Richard Janzaruk presented the following awards:

Low Gross	Dick Weinzapfel	74
Low Net	Dick Hurley	81-16-65
Closest to pin on #7 hole		Bill Current
Honesty Award	Tom Boyd	120

President Lind thanked Dr. Dick Janzaruk for the splendid job he did in planning the outing.

Dr. Paul Van Dorn announced the American Association of Dentists Dinner Meeting would be held September 7, 1974, at the Howard Johnson Downtown Motor Lodge in Indianapolis.

Dr. Dan Rohn explained that the Indiana Dental Association has been a leader in dealing with various types of third party dental coverage. He also said, the Indiana Dental Association's position had not been accepted by all

third parties even though it has been felt the Indiana Dental Association plan was best for all concerned.

Dr. Dave McClure pointed out the unity of the Madison County Dental Society in following the Indiana Dental Association principles of acceptability by not sending x-rays with treatment plans submitted for evaluation of coverage by a third party.

The tape-slide sequence explaining the Indiana plan was shown.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 197 A]

[Illegible]
5050 N. Clinton Street
Fort Wayne, Indiana 46825

December 21, 1971

Dr. William G. Schmidt
2032 Lincoln Avenue
Evansville, Indiana 47714

Dear Dr. Schmidt:

The following is a resume of the actions taken by Isaac Knapp, in dealing with the Aetna Insurance Companies' administration of the International Harvester Insurance Program.

April 15, 1971—At Issac Knapp's last regularly scheduled board meeting it was decided that communications should be made with Aetna concerning the pending insurance plan. A letter was sent to Dr. Downes asking him to appear for a meeting with representatives of Issac Knapp. Dr. Downes declined to come claiming that the plan had not been fully formulated yet, and that he did not have sufficient knowledge to justify a meeting. It was decided that a special addition of Issac Knapp's monthly newsletter, *The Reveille*, would be published in July. Ordinarily the first newsletter is published in September, however, with the advent of the new International Harvester plan pertinent information could be given to the membership as soon as it was made available.

June 27, 1971—A meeting was held in Indianapolis with Dr. Downes and other representatives of Aetna. In attendance at this meeting was the full body of the Indiana State Prepayment Committee and other interested parties from effected constituent societies.

Issac Knapp was represented by about 6 men including their president, secretary and regular representatives. Dr. Downes discussed the plan with us and was told at that time that we found the plan did not meet the guidelines stipulated by the Indiana State Dental Association and that the membership would be informed of such.

July 3, 1971—A special meeting was held by the president of Issac Knapp and those members of the Board of Directors and Prepayment Representatives that were available to discuss and review notes taken at the meeting on June 27. It was decided that another meeting would be called on July 5.

July 5, 1971—A dinner meeting was held. Dr. Schmidt's letter on peer review and his meeting with Dr. Downes was presented and discussed. It was decided that a special board meeting would be held on July 7th.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 372 A, F]

RAMIFICATIONS OF THIRD PARTY PROGRAMS AS RELATED TO THE "INDIANA PLAN"

The problems associated with third party programs are many, but I believe the "Indiana Plan" to be sound and if we work together, we can win this battle. We are fighting an economic war where the very survival of our profession is at stake.

How long can some of the leaders of dentistry in other states be so complacent and willing to fall into the trap that is being set for us. If only they would take the time, to see from whence come the arrows that are heading in our direction. The Delta Dental Plans have bedded down with the unions and have been a party to setting up the greatest controls that any profession has ever known in a free society. I feel we in Indiana will be vindicated in the next few years, when dentists in other states wake up and realize that they have been had. A few weeks ago the Chicago Dental Society had an editorial in their Journal about the controls that the dental service corporation was placing on its members. The Journal of the Academy of General Dentistry just recently had a good editorial about the controls by the Blues in Pennsylvania. We will see more and more of this dissent and the time will come when Indiana will say, we told you so.

The name of the game is money. The government and labor are determined to reduce the cost of the dental health dollar at the expense of the dentist. There is no way a dental service can be rendered cheaper when the third party has to have its share of the dollar.

Already we are locked into a fee freeze that could completely control the quality of dental care, if left on long enough. If these controls continue, * * *

* * * *

Presented by David B. McClure, D.D.S. at the Indiana Dental Association's Council on Dental Care Programs meeting, March 14, 1974.

> * * * dentists or laymen), I could be placing myself in jeopardy as an accessory to the illegal practice of dentistry. Any good dentist will tell you that an accurate diagnosis cannot be made without the examination of the patient and all pertinent diagnostic aids. I will be happy to have you send a licensed Indiana dentist to my office to examine the patient and at that time I will review with him all of my diagnostic records.

It is important that all of you here today become better informed so that you can go back to your components and spread the word and educate every member. In East Central, we expect to have every member informed as to the contents of the contract and we will tell them what we are going to do as individuals. We also expect to show again and again the film strip on the "Indiana Plan".

I would like to commend Dr. Compton and his group for what they are trying to do in Indianapolis and I want them to know that Bill Schmidt and I will do anything we can to help them.

Gentlemen, the future of dentistry is on the line and we must take a stand.

It is quite likely that our younger colleagues will have a difficult time meeting their bills unless they follow the dictates of the third party.

If they find they cannot meet their bills when they submit to the third party pressures, I have asked them to let us know and those, like myself, who have been practicing for twenty years will help them get a loan to carry them through. I feel that we must have this kind of commitment to each other if we are to succeed. Thorton Wilder once said, "I love success, we never get used to failure." So I say to you—let us stick together and be successful.

* * * *

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 477 B, C]

NEWS RELEASE

For: Indiana Federation of Dentists
President, Dr. David B. McClure
1415 Raible Avenue
Anderson, Indiana 46011

Contact: Dr. David B. McClure
(317/642-3263) or
(317/642-7558)
or
Barbara Rafferty
(317/632-6501)

August 25, 1976

For Immediate Release

MADISON COUNTY, INDIANA,
DENTISTS ORGANIZE NATION'S FIRST UNION
OF PRIVATE PRACTICE DENTISTS

The first union for private practicing dentists in the country has been formed in Madison County, Indiana.

The action comes as a surprise from a state and area noted for its conservatism but Madison County dentists believe that unionizing is the only way dentists can meet the challenge of providing quality dental care for their patients under terms of dental health insurance programs, according to Dr. David B. McClure, Anderson. He is president of the first local of the Indiana Federation of Dentists.

Noting that unions are exempt from anti-trust laws, he says that unionizing will enable dentists to be heard in negotiating with insurance companies on the quality of care and conditions of treatment. Long active in the state's dental professional organization, the Indiana Dental Association, Dr. McClure stated that such associations

are subject to anti-trust laws and therefore without the bargaining power of a union.

IDA members, however, have been concerned over terms of dental insurance programs which frequently call for "least expensive adequate" treatment rather than allowing the dentist to choose the treatment he considers best for an individual patient. They also have questioned the policy of some insurance companies who base reimbursement on the submission of x-rays rather than case studies, and the extensive additional paperwork required of dentists.

"Since insurance contract terms affect our working conditions and our relations with our patients, we believe we should be able to negotiate them at the bargaining table," Dr. McClure stated after the Madison County dentists organizational meeting last night (August 24) in Anderson.

Although affiliated with the American Federation of Physicians and Dentists (based in Springfield, Mo.), Dr. McClure pointed out that the new local is "pretty much autonomous—and striking is not part of our plans." The American federation is made up primarily of physicians and dentists employed by hospitals, clinics and industry. The Madison County unit chose to become part of the national organization because of the need to be part of an organization already registered with the National Labor Relations Board.

They hope that organizing now will enable them to be heard in the interpretation of the dental coverage portion of the new, yet to be negotiated, United Auto Workers contracts to go into effect Oct. 1. It is estimated that 20,000 UAW members live in Madison County where General Motors operates two plants. They are among the 1.5 million Hoosiers already covered by some form of dental insurance. That number is expected to increase rapidly as new benefits are won by other workers and with the advent of some form of national health insurance.

Other dentists around Indiana are watching the Madison County local with interest and indications are that more locals will be formed.

Union leadership also includes Dr. R. Dan Rohn of Alexandria, former president of the IDA and current chairman of its Council on Dental Care Programs; Dr. David G. Yater, Anderson, secretary; Dr. David C. Steele, Alexandria, treasurer, and Dr. James H. Worster, Anderson, current IDA treasurer and member of the union board.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 484 A-C]

September 8, 1976

Dr. William Schmidt
Evansville, IN

Dear Bill:

Received your letter today. I will attempt to answer as many of your questions as possible as satisfactorily as I possibly can.

To answer why we consider the formation of a union as our most viable alternative I would have to at this time give you three primary reasons.

Having attended the last two House of Delegates sessions and council on Dental Care programs meetings I have been aware that there is a prevailing sense of apprehension in respect to anti-trust liability. The association has been consistently warned by legal council to be very careful in its actions and the wording of all official responses to third parties regarding our policies and positions. With the very real spectre of anti-trust violation hanging over their head the council is having increasing difficulty formulating a positive action in behalf of the membership, in view of the recent F.T.C. suit and investigation, and the proposed and anticipated actions of the Justice Department in these areas. One of the major advantages to unionization is the unquestioned immunity to anti-trust liability.

The second reason is our realization that the I.D.A. has represented us magnificently to this inning of the ball game and has been forced to involve itself in areas which go far beyond it's original scope of intent. If you will read the object of the association in the constitution and by-laws, you will realize that the association was not designed nor intended to represent us in socio-economic or political areas. This is in fact the basis of our defense in the suit with the F.T.C. Our reason for not honoring

their subpoena for our Code of Ethics was that the A.D.A. and it's affiliates were not formed to better the pecuniary interests of the members and therefore we don't fall under their jurisdiction. We feel that to ask the I.D.A. to continue to expand its scope of involvement into areas it was never intended to enter will eventually force a reconcilliation of the issues in a Court of Law with the strong possibility of our receiving an adverse ruling. It is our opinion that a more suitable vehicle is needed to represent us in these areas and that a union is the most advantageous choice to satisfy the needs previously mentioned.

Our third reason is to give our members a new banner around which to rally and to forge new feelings of unity and purpose. You ask how has our announcement of organization been received? At this time the response from the general public has been very positive and sympathetic. We have very subtly identified the Insurance industry as our adversary and this just so happens to be a party the public already considers their adversary. At this time we are viewed as the champions of the public interest against unwarranted intrusions by insurance companies. Realizing the prevailing feeling of the people, the local union has tendered an offer to help us achieve our purpose in any manner possible, we plan to exploit their offer as advantageously as possible. Our response from the profession in other areas has been overwhelming. To satisfy all the requests for information we are planning a seminar October 10 here in Anderson for interested parties throughout the state to explain how, and what we have accomplished.

We have at this time received no response from management. On September 9, we have a special meeting to ratify our State and Local Constitution and By-laws. We have thus forsigned 95% of the practicing dentists in Madison County and the remaining men will most probably come in to the fold after an opportunity to read the Constitution and By-laws. We don't anticipate any holdouts and have kept the retaliatory and economic pres-

sures we could apply to non-members very low key and tried not to threaten any of our members.

We will be affiliated with the American Federation of Physicians and Dentists whose main office is in Springfield, MO. It was necessary for us to affiliate with an existing union because we could not satisfy the requirement of having an employer-employee relationship. They are granting us the right to have the charter for Indiana dentists and we will remain autonomous and separate entity except at the national level where we will be associated with physicians for political impact and leverage. We will operate within the state as a separate, autonomous, entity with no interaction with the I.D.A., which conduct could possibly jeopardize our anti-trust immunity.

Our dues structure might appear to some to be exhorbitant or prohibitive but to our members, who at all cost want to avoid the Delta concept, it appears dirt cheap. The state dues will involve $100 application fee and $200 per year with our local dues set at $300 per year. The most common response has been; Are you sure that is enough? You see Bill, we have explained the Delta concept and what it means financially to participating members.

If you need any further information please feel free to write or call at any time. I have enclosed some additional material for your personal edification. Good luck in Seattle.

Sincerely,
D. G. Yater

DGY:DS
Enclosures

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 486 A-C]

MINUTES

Board of Trustees' Meeting
Indiana Dental Association
October 1, 1976
Howard Johnson's Motel
Bloomington

PRESENT *Trustees*: Drs. H. W. Gilmore, IDDS; L. L. Rooksby, NW; W. B. Anshutz, Jr., WI; R. J. Clark, SC; C. R. Ricci, WV; E. E. Brinker, FD; G. S. Gardiner, IK; J. W. Bayley, WC; R. E. Halle, BH; J. L. Portzline, EI; E. M. Benjamin, GD and H. G. Thomas, EC

ADA Trustee: Dr. L. J. Phillips, Trustee, Seventh District

Officers: Drs. R. M. Stetzel, President; M. G. Stevens, President-Elect; W. K. Carr, Vice President; R. A. Rahe, Speaker of the House; D. C. Lind, Vice Speaker of the House and J. H. Worster, Treasurer

Staff: Mr. G. E. Coons, Executive Director, Mr. J. M. Quinn, Assistant Executive Director and Miss L. S. Dougherty, Secretary

Guests: Drs. S. L. Carr (attended meeting representing North Central Dental Society due to absence of Dr. J. T. Eastman); D. B. McClure; R. D. Rohn; R. A. Moon, D. E. Compton, J. W. Linquist; A. Dunfee; R. C. Harris; R. E. McDonald; J. R. Platt; G. O. Sagraves; J. D. Frey, R. L. Gayle and D. G. Yater

President Stetzel called the meeting to order with an invocation.

Dr. Ricci, Secretary, called the roll of trustees and announced a quorum was present (All trustees were present except Drs. Stucker and Eastman who had written in advance of the meeting that they could not attend due to other commitments.)

Dr. Ricci reviewed the Board's May 4, 1976 minutes and minutes were approved as distributed and reviewed. *Motion by Dr. Benjamin and seconded by Dr. Anshutz to approve the minutes.* PASSED.

Mr. Coons, Executive Director, noted that directives via the May 1976 House of Delegates relative to the Board of Trustees would be covered later in the agenda by reports of officers, council and committee chairmen.

Dr. Phillips, Trustee, American Dental Association, presented an informational report of ADA activities supplementing his written report of the Board's August meeting. Dr. Phillips' report included the following items:

1. This was his last official report to the IDA Board of Trustees as ADA Trustee. He expressed his appreciation for the cooperation and support he had received from the IDA Board. He noted he had enjoyed serving Indiana and Ohio as trustee.

2. He said his report to the Indiana delegates and alternatives on Sunday, October 3 would include a review of all the resolutions presently filed with the ADA for consideration at the Las Vegas meeting. He invited all IDA members to attend.

3. He discussed the American Fund for Dental Health grant for a preventive dental health demonstration project and the fact that Indiana had applied to participate in the program.

4. He noted that the IDA's Speak Out for Dentistry Program on Thursday was well attended and from all indications a success.

5. The ODA Annual Meeting was most enjoyable. He was most grateful for the expressions of appreciation by him and Mrs. Phillips. Relative to the ODA meeting he noted he had met with Dr. Clemens, Trustee-Elect and offered his help in any way possible.

6. Dr. Phillips discussed *trends* he saw developing at the national level.

a. A greater tie between ADA and Delta.

b. Delta report is somewhat critical of states that do not cooperate.

c. Finances for the ADA continue to be a problem.

d. ADA position paper regarding cost of dental care.

e. Government programs will push for a set fee schedule. Fraud is being checked in many states.

f. Dentists are very individualistic. This is good and at the same time it can work to their disadvantage because of lack of unity.

g. Dr. Phillips concluded with an expression of appreciation for the support and cooperation received from the IDA.

Dr. Stetzel thanked Dr. Phillips for the Association for his many contributions and sacrifices to represent the IDA. He said we regret you did not get the office of treasurer of ADA.

Dr. David B. McClure, President, Indiana Federation of Dentists, reported on the activities of the union. He noted that about 80-90% of dentists practices in the Anderson area is covered by one insurance carrier; therefore, the dentists there believe they need more muscle than organized dentistry can give them. They found that via a union they could go beyond dental association activities. In their opinion the union movement will not weaken the IDA but will supplement it.

They are now registered with the National Labor Relations Board. They have written to the presidents of U.A.W., General Motors, Connecticut General, et al, stating that they wish to have input to the new local contract provisions.

Dues for the I.F.D. are $100 application fee, $250 local and $250 state. Then, there is a $25 assessment for additional local needs. There are approximately 45 members. They cannot accept donations; however, there is a provision for a member at large status at $100 application fee and $250 dues.

The I.F.D. will establish a dental manpower committee to monitor movement of dentists in and out of the county.

There will be a December 12 symposium on dental unions sponsored by the I.F.D.

Another reason for forming the I.F.D. was that the word was out that within 60 days the insurance companies, unions and management would "break the back" of the local dentists.

Meetings with Connecticut General have indicated they will ask for x-rays; however, if they are not sent they will not demand them.

There is considerable interest in this idea from within and without the state.

In answer to questions, Dr. McClure said he hoped they would not have to resort to strike or economic pressures; however, if they were to be a true union this may become necessary.

There was general discussion regarding the I.F.D. movement—pros and cons. Dr. K. Carr expressed means of preventing more unionization if the dentists would become more united, implement the bill payer plan or seek relief from anti-trust via Congress. There was discussion regarding conflict of interest. Dr. McClure did not believe there was any conflict and said their members would not resign from the IDA.

Officer Reports:

PRESIDENT STETZEL reported on the following Association items of business:

1. *ADA Diverse Policy Survey*—He reviewed the ADA request of last May and brought the trustees up to date with correspondence on the subject. This included the Texas Dental Association material. Copies of correspondence and the survey form were distributed.

Dr. Bayley moved and Dr. Clark seconded a motion to reaffirm the Board's May 1976 decision to not participate in the ADA diverse policy survey and so advise the ADA Council on Dental Care Programs. And be it further

RESOLVED: *That the Central Office Steering Committee when appropriate (i.e., if ADA continues with survey) send an all membership mailing explaining why the Board took this action (Note: First of letter should state in bold prin DO NOT PARTICIPATE IN SURVEY.* PASSED.

Dr. Bayley moved and Dr. Gardiner seconded a motion that the Indiana, ADA delegates and alternates consider whether or not Indiana should introduce a resolution and/or position paper to the ADA House of Delegates regarding Indiana's positive position on this matter. PASSED.

2. *American Dental Hygienists Association Regarding Preceptor Training*—The ADHA requested that the IDA adopt a resolution opposing preceptor training. After discussion of the subject, which most agreed was in a state of change, the Board adopted the following:

Dr. Gilmore moved and Dr. Rooksby seconded a motion that the Indiana, ADA delegation support the ADA Council on Dental Education Resolution No. 4 which would be the Association's formal reply to the ADHA. PASSED.

Note: Two "no" votes—Drs. Bayley and Ricci.

3. *California Resolution Regarding Profession Exemption from Anti-Trust*—There was discussion as to whether such legislation might apply to Delta plans. It was generally concluded it would not.

Dr. Portzline moved and Dr. Rooksby seconded a motion that the Indiana, ADA delegation support the California resolution and so advise the California Dental Association. PASSED.

4. *American Academy of Periodontology Regarding Failure to Diagnose*—This subject was brought to the Board's attention for information to their constituents.

5. *Task Force on Component Society Organization and Structure*—Dr. Stetzel reported that the task force had been appointed per the House and Board's direction. The task force met August 18 and again October 1.

Dr. K. Carr attended the October 1 meeting and reported that the task force would conduct an all membership survey on the subject and prepare recommendations to the Board of Trustees in January.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 489 A, B]

INDIANA FEDERATION OF DENTISTS
1827 North Madison Ave.
Anderson, Indiana 46012

October 26, 1976

Dr. Leroy H. Kulis
100 Elm Street
Kent, Ohio

Dear Dr. Kulis:

Dr. Gene Dellinger of Fort Wayne has asked that I send you a current status report of our dental union.

As you know, we announced that the union was formed on August 26th. The truth of the matter is that we took a vote to form the union on that date and we still had all of the paper work to complete.

The paper work took a great deal of time since this was the first time a union had been established for private practicing dentists. I guess we must have rewritten the constitution and bylaws a dozen times.

On October 1st, we became official. This was the date we were registered with the National Labor Relations Board.

The first action we took was to send letters to the President of General Motors, the President of National U.A.W., and the President of Connecticut General. The purpose of the letter was to alert these individuals to the fact that we did exist and would be concerned about contact language that affects our working conditions. As of this date, we have heard from all parties.

It is very interesting to note the change in the local union officials. Eight months ago they were trying every trick in the book to bring us to our knees. They even tried to campaign for enrollment to set up a U.A.W. closed panel.

Since we formed our union, it throws us in the same ball park and they may still dislike us; but they have to work with us. To give you an example of this, notice the enclosed clipping of October 21, 1976. Mr. Miller, the U.A.W. Local # 663 President is no longer saying the dentists are the villians, but the Insurance Co. is now the adversary.

We have always been very unified in the Anderson area, but now we feel much more secure not having the anti-trust albatros around our necks.

We have been in the process of hiring a part time Executive Director and setting up a central office. We are asking all of our members to send us any letters that they received from carriers, such as requests for x-rays, etc. I have been answering these letters for the practicing dentists.

We are holding a symposium to share with the Indiana Dental leaders the mechanics of forming local chapters.

I hope that sometime in early 1977, we can hold a National Symposium in Indianapolis.

If you or any of your colleagues want to come over to the symposium of December 12th, we would like to have you.

Sincerely,

DAVID B. MCCLURE, D.D.S.
President

DBMcM/df

cc: Dr. Eugene Dellinger
Dr. William G. Schmidt

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 522]

MINUTES OF SPECIAL MEETING OF THE EXECUTIVE COMMITTEE OF THE INDIANA FEDERATION OF DENTISTS

A special meeting of the Executive Committee of the Indiana Federation of Dentists was held on Tuesday, October 12, 1976, at 6:30 o'clock p.m. at the Yule Apartments, Alexandria, Indiana, pursuant to call of the President, Dr. David B. McClure. Present were all officers and members of the Executive Committee except Dr. James Worster.

The members of the Executive Committee discussed discipline or acts of reprisal against non-member dentists and dissident members. After lengthy discussion the general consensus was that lawful severe measures would be instituted only as a last resort, but that the attorney for the organization should be asked to advise the Executive Committee the lawful measures that could be taken in such cases.

The Executive Committee then discussed the feasibility of initiating a negotiating session with the local United Auto Workers 662 and 663 unions and Connecticut General Insurance Company, the insurer. Although no motion was made the consensus of the Executive Committee members was to proceed with an attempt to enter into discussions with United Auto Workers Unions and Connecticut General Insurance Company prior to the pending contract settlement between the United Auto Workers Unions and General Motors Corporation.

There being no further business to discuss, the meeting was upon motion to adjourn, duly seconded, adjourned upon unanimous vote.

Respectfully submitted:

/s/ D. G. Yater
DR. DAVID G. YATER
Secretary

APPROVED:

/s/ David B. McClure
DR. DAVID B. MCCLURE
President

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 537 A]

MINUTES OF ANNUAL MEETING OF THE INDIANA FEDERATION OF DENTISTS

An annual meeting of the Indiana Federation of Dentists was held on Sunday, April 24, 1977, at 2:00 p.m. at the Sheraton Motor Inn, Anderson, Indiana, pursuant to a letter from Dr. Richard Janzaruk. Members present were Doctors John Boyle, Victor Clevenger, William Conrad, Phillip Frist, Richard Janzaruk, David McClure, Howard Mohler, Elmer Moreillon, James Pierce, Jim Pridgeon, Michael Robinson, Dan Rohn, William Shoemaker, Garry Smith, David Steele, Paul Van Dorn, Warren Westbrook, David Yater, Max Culler, J. Bayley, R. A. Fontaine, R. Oliver and V. Bailey.

The meeting was called to order at 2:14 p.m. by Dr. David McClure. No minutes of previous meeting were read as this was the first annual meeting. Dr. McClure gave a summary of the letter received by the Indiana Federation of Dentists from the Federal Trade Commission and read the response sent to them by Mr. Fowler, our attorney. Dr. McClure then read the second letter that we received from the Federal Trade Commission.

Dr. McClure then informed the members of trips to Fort Wayne, South Bend and the West Side Study Club of Indianapolis concerning formation of local chapters in these areas.

Dr. McClure finished the President's report with his feelings concerning the actions of the Federal Trade Commission.

Dr. Oliver opened the discussion of Work Rules concerning diagnostic aides and read in part a letter written by Dr. Walker in 1974. He then read a proposed work rule concerning this as follows:

> Proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids, with a history and with all clinical findings. No one facet

> of this process is now, or ever has been, recognized by the profession as a substitute for the complete process. To represent otherwise would subject the patient to substandard care.
>
> The patient's dentist, therefore, has a moral and legal responsibility to not allow a determination of his patients condition to be made for any purpose, without the benefit of a compete examination which takes into account all of the elements described.

Dr. Rohn moved that the Indiana Federation of Dentists adopt the preceding work rule as read by Dr. Oliver and as edited by the Executive Committee and our attorney. Dr. Fontaine seconded and the motion carried by unanimous voice vote.

[FTC COMPLAINT COUNSEL TRIAL EXHIBIT CX 549 A]

Vol. 1, No. 2
September 1, 1977

AWARE

As professional individuals we are all concerned with providing the highest quality of care for our patients in the most comfortable manner with the lowest practical cost. We are also interested in mutual respect and empathy with our patients.

Part of our felt duty as professionals is helping our patients to receive the benefits due them under third party prepayment arrangements (so called dental insurance). We are thus rightly concerned with helping to design programs which protect the patient-dentist relationship, protect privacy, and protect the rights of the patient and dentist to determine the appropriate treatment plan without unnecessary third party intervention.

We are now *AWARE* that it is up to the Federation with its constitutional and legal ability to act in the socio-economic areas to help protect the patient's and dentist's rights. The I.D.A. has been forced to get out of the game. Either we as concerned professionals join the new game or refuse to play and abandon the patient. What a choice!

All but a few dentists in our four county area are now members of the Federation. This certainly indicates the amount of caring and concern our fellow dentists have for their patients. We are thankful to practice in communities where others of our profession care enough to get involved.

We can understand the concern of the few who have not yet joined us.

EDITORS:

Dr. J.D. Rodkey
Dr. J.W. Bayley

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 544 A]

INDIANA FEDERATION OF DENTISTS
Chapter Number Two

Affiliate of the
American Federation of
Physicians and Dentists

Indiana Federation of Dentists
Chapter # 2
July 13, 1977

The meeting was called to order at 8:00 P.M. at Dr. Paul Draper's home. Minutes of last meeting were read and approved as submitted.

A review and analysis of the chapter events since the last meeting was given by Dr. Oliver:

a. Five bottles of liquor were given as door prices at the Chic-Nic.

b. Drs. Fontaine, Oliver, Bayley and E. Smith were named negotiators for the chapter. Dr. Fontaine will call a meeting with Mr. Fox of the City of Lafayette and Mr. Roger Hayley of BC/BS later in the month.

A discussion of unfinished business followed:

a. Dr. Bailey of Frankfort stated that a problem existed with Travelers (Peter Paul Co.) concerning X-ray submission. The negotiating team will contact their chief steward and offer to help.

b. The Alcoa contract will be reviewed by Dr. E. Smith and he will contact Mr. Ken Ratcliff in that regard.

c. Dr. Max Lecklitner's follow-up with REA Magnet Wire was unavailable.

d. A review of the State Meeting was given by Dr. Oliver.

e. It was brought to our attention that a list of dentists was posted at Arni's. The list comprised of names of "co-operating" dentists in Lafayette and West Lafayette.

New Business:

a. It was decided that fifteen members will contact two busineses each to ascertain their dental insurance status (if any).

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 612 A-C]

JOHNS-MANVILLE
SALES CORPORATION
920 West Washington Street
Alexandria, Indiana 46001
(317) 724-4421

March 30, 1978

United States Administrators
P. O. Box 54076, Terminal Annex
Los Angeles, California 90054
Attn: Dr. J. Friedman

Dear Dr. Friedman:

Attached are copies of the listings of dentists in the community surrounding the Alexandria Plant.

Would you please contact these dentists and compile a list for us of those who are willing to send x-rays as required.

Thank you for your help.

Very truly yours,

/s/ J. J. Tolbert
J. J. TOLBERT

ZIP CODES
Chesterfield 46017
Alexandria 46001
Pendleton 46064
Middleton 47356

Anderson unless noted

Dentists

Bartels Robt D
Practice Limited To Orthodontia
Chesterfield Office Hours On Wednesday
Chesterfield Office 523 W Plum
1612 W McGalliard Rd Muncie 289-3909

Bigelow Jos L
Practice Limited to Oral Surgery
2101 Jackson 642-9738

Boyle John T 815 Meridian 644-1111

Clevenger Victor
Practice Limited To Orthodontics
First Savings Tower Suite 703 649-3361
ad Win I 603 Anderson Bk Bg 642-7717

Cribbs Wm P 610 Tillotson Av Muncie 288-5448

Crouse Geo C 615 Anderson Bk Bg 644-8116

Crouse Jack C 615 Anderson Bk Bg 644-1000

Culler Max B
Practice Limited To Orthodontics
522 W 8 643-6604

DeBruhl Brank B
By Appointment Only—General Dentistry
St Rd 236 Middletown 354-4796

Druley Myron J 606 Anderson Bk Bg 644-6512

Fischer Richard B
By Appointment Only—Family Dentistry
Phone Answered 24 Hours
1827 N Madison Av 642-2900

Follmar Jerome A 123 W 12 649-5523

Forgey Joe E
Practice Limited To Dentistry For Children
110 Lakeview Dr Noblesville 773-3617

Frist Phillip 731 E Hartman Rd Suite A 649-0611

Gephardt David A
Ofc 815 W 8 643-7485
Ofc 815 W 8 643-3061

Gephardt David C
Ofc 815 W 8 643-3061
Ofc 815 W 8 643-7485

Gilliom Arthur V 719 E 8 642-2823

Harrison Richard E Dental Corporation
255 Citizens Bank Bldg 643-8141

Hollar H S 617 Anderson Bk Bg 643-3064

Hoppes Dean E 808 E 644-8532

Hougland Hub
Practice Limited To Children's Dentistry
112 Ridge Rd Muncie 284-1883

Hudson C Merrell 1130 Lincoln 644-4765

Hull James R
Family Dentistry—By Appointment
3600 E Memorial Dr Muncie 284-6446

Janzaruk Richard DDS 2403 Raible 649-5257

Johnson N Douglas
103 E State Pendleton 778-2027
Residence call 255-3572

Jones Charles P
First Savings Tower Suite 505 642-3100

King Thos N Dental Corp
General Dentistry—Hours By Appointment
4019 Columbus Av Suite C 642-8286

Lackey Robt L 219 Citizens Bk Bg 642-0591

Lau Kenneth
Family Practice
Hrs By Appointment
122 W State Pendleton 778-7113
Residence call 253-7428

Mc Callister Wayne K 2906 E 8 649-6015

McClintick O E 608 Anderson Bank Bldg 644-4119

McClure David B
Practice Limited To Pedodontics
1415 Raible Av 642-3263

Mohler Howard H
Practice Limited To Oral Surgery
1431 N Madison Av Suite 3 642-7400

Moreillon Elmer L 2304 B Meridian 643-7214
Morris Raymond C 2012 Nichol Av 642-2614
Myofunctional Therapy
610 S Tillotson Av Muncie 288-8022
Pierce J G 3506 St Rd 9 N 642-1612
Pridgeon Jas L 523 Plum Chesterfield 378-0271
Reibel Peter R
Practice Limited To Prosthodontics &
Occlusal Dysfunction
7172 N Keystone Av Suite E Indpls 255-6471
Reimer John DDS Inc 1700 N Bway 642-3588
Remley Basil W
Practice Limited To Oral Surgery
2101 Jackson 642-9738
Robbs John A 700 Nursery Rd 642-5783
Robinson T Michael
By Appointment Only
522 W 8 Suite 6 643-5356
Rodgers Harold T
Hours By Appointment
2401 Raible Av 642-5253
In no answer call 643-5311
Salyers Wm L 353 Citizens Bk Bg 644-5165
Schussler H Tom
2016 W McGalliard Rd Muncie 289-7233
Shoemaker W R
Periodontist
Hours By Appointment Only
1328 Drexel Dr 643-3592
Simmonds James F St Rd 67 E Daleville 378-5790
Smith Garry L
1431 N Madison Av Suite 5 649-3388
Smith Geo Creston 210 E Cross 644-1098
Steele David C 113 S Harrison Alexandria 724-7777
Stiren Fredric M
Practice Limited To Endodontics
By Appointment Only
5023 W 56 Indpls 257-5166
No answer call Indpls Ind 849-6941
Vanarsdall W A H 455 Citizens Bk Bg 644-5014

Van Dorn Paul Robt
Practice Limited To Periodontics
1106 E 8 649-4241

VLADOIU ROBT J DDS

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We Participate in U A W Dental Plans
1) We Accept Assignment Of Insurance Payment
2) We Fill Out Your Dental Insurance Claims
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Southeast Corner I-69 (New 37) At 71st St.
Lakewood 7100 Office Bldg
5987 E 71 Suite 105 Fishers 842-2337

Weinzapfel Richard W
Practice Limited To Pedodontics
1827 N Madison Av Suite A 642-1882
Westbrook Warren H
By Appointment Only—General Dentistry
1107 W 8 643-4100
Worster James H 123 W 12 642-3124
Worster Paul T
Practice Limited To Orthodontics
522 W 8 643-6604
Yater David G 1827 N Madison Av Suite A 649-1226

Dentists

Fischer Richard B
By Appointment Only—Family Dentistry
Phone Answered 24 Hours
1827 N Madison Av Anderson 642-2900
Fisher A W 311 N Canal Alexandria 724-4007
King Thos N Dental Corp
4019 Columbus Av Suite C Anderson 642-8286
McCallister Wayne K 2906 E 8 Anderson 649-6015
Mohler Howard H
Practice Limited To Oral Surgery
1431 N Madison Av Suite 3 Anderson 642-7400
Pridgeon Jas L 523 Plum Chesterfield 378-0271

Robinson T Michael
By Appointment Only
522 W 8 Suite B Anderson 643-5356
Rodgers Harold T
Hours By Appointment
2401 Raible Av Anderson 642-5253
In no answer call Anderson 643-5311
Rohn Dan 109 W Monroe Alexandria 724-3276
Smith Garry L
1431 N Madison Av Suite 5 Anderson 649-3388
Steele David C 113 S Harrison Alx 724-7777
Westbrook Warren H 1107 W 8 Anderson 643-4100

MARION, INDIANA 46952

Dentists

Babcock Robt A 614 Marion Natl Bk Bldg 664-0382
Brown Donald D
Oral & Dental Surgery
611 Marion Natl Bk Bg 664-5247
Brown P Edwin
General Dentistry
1900 Kem Rd 664-8081
Bruner Geo K 821 N Western Av 668-8907
Catey Philip L
General Practice—Office Closed Mondays
115 S 2 Gas City 674-7241
Colwell Michael 305 E Anson 998-2741
Daily R V 114 W 2 664-0704
Daubenspeck J W 300 S Main Jonesboro 674-5515
Dreiman Bernard B
Oral And Maxillofacial Surgery
444 Wabash Av 664-1076
Dryer Bruce E
By Appointment Only
215 E Wash Fairmont 948-4107
Fall Jas L 2301 S Adams 664-7595
Fries George W
General Dentistry
The Davis Clinic Inc
131 N Wash 664-0511

Gorman John C D MD
Practice Limited To Orthodontics
444 Wabash Av 664-3030
Henderson Richard P
708 Marion Natl Bk Bg 664-8832
Himelstein Morris
No Appointment Necessary
Wed & Sat 9AM-12Noon
Mon-Tues-Thurs-Fri 9AM-3PM
802 N Baldwin Av Suite 5 664-6311
Jackson Earl W 537 E 31 662-6851
Lewis Ben I
Closed Mondays
114 S 1 Gas City 674-1642
Milford Wm E 315 N Western Av 664-1237
Miller F D Dental Clinic
103 N Jeff Converse 395-3185
Newbauer Bernard A
General Dentistry
1900 Kem Rd 664-8081
Richardson Geo G 722 S Wash 664-8754
Roper Wm Z
Practice Limited To Orthodontics
1102 N Wabash 662-3881
Stiefler D N 911 N Western Av 664-1743
Tade E Harold 604 Marion Natl Bk Bldg 664-7273
Todd Jackson D
Oral And Maxillofacial Surgery
444 Wabash Av 664-1076
Urschel Lewis
Oral Surgery
The Davis Clinic Inc
131 N Wash 664-0511
Vogel John E 622 S Branson 664-8463
Winder Geo E DDS
General Dentistry
The Davis Clinic Inc
131 N Wash 664-0511

MUNCIE, INDIANA

Dentists

Baldwin Fred 1545 W Jackson 284-3881
Bartels Robt D
Practice Limited To Orthodontia
1612 W McGaillard Rd 289-3909
Blake Thos L DDS Inc
Practice Limited To Extractions &
Oral Surgery
1806 W McGaillard Rd 288-2522
Boyd T M 321 University Av 282-7320
Calvin Warren E
Practice Limited To Orthodontia
1535 W Jackson 284-5353
Combs Wm M 500 W Main 288-8832
Craig John A 1608 W Yale Av 288-4832
Cribbs Wm P 610 S Tillotson Av 288-5448
Current Wm C 1606 W McGaillard Rd 288-1475
Ellison Richard T DDS Inc
610 S Tillotson Av 289-0236
Fullhart T L
Hrs By Appointment Only
106 Ridge Rd 284-2330
Gamble F W 204 Rose Ct 282-4772
Grasso Anthony M
Practice Limited To Extractions
And Oral Surgery
3111 W Jackson 289-3424
In no answer call 288-7871
Harris Darryl C
Professional Corporation
Practice Limited To Children's Dentistry
2220 W McGalliard Rd 288-8812
Hennigar Jas C 4108 N Wheeling Av 284-2363
Hodson F A 2809 Godman Av 288-5422
Hougland Hub
Practice Limited To Children's Dentistry
112 Ridge Rd 284-1883
Hulecki Philip Dr 610 S Tillotson Av 288-9171

Hull James R
Family Dentistry-By Appointment
3600 E Memorial Dr 284-6446
Hurley J Richard DDS Inc
1900 W McGalliard Rd 289-1578
Jennings Donald E 2301 W Jackson 288-1334
Lambert Neal E 315 W Wash 282-2265
Lang L A 2724 W North 284-5166
Leff H H 202 Reserve 284-7242
Lind D C
Junction US 27 & State Rd 32
817 E Washington Winchester 584-0971
Ludwick Jacob W 129 W Oak Dunkirk 768-7715
Residence
205 N Manor Ave Albany 789-6529
Manning Wm J 221 Stradling Rd 282-3377
Mc Callister Wayne K 2906 E 8 Anderson 649-6015
Mc Crady M T State Rd 67 N Albany 789-4454
Moser Jas P 321 Univ Av 284-3567
Myofunctional Therapy
By Appointment Only
610 S Tillotson Av 288-8022
Nelson Geo T 3421 S Madison 284-7288
Nowakowski Allan R
Practice Limited To Oral Surgery
1406 N anville Av Suite 205 286-0771
Patberg N F
Hrs By Appointment Only
106 Ridge Rd 284-2330
Porter E H 211 W Main 288-6121
Risk Paul B
Practice Limited To Orthodontics
610 S Tillotson Av 289-2377
Rohn John W 919 E Smith Yorktown 759-5002
Rothhaar Raymond E DDS Inc
Practice Limited To
Pedodontics (Children's Dentistry)
610 S Tillotson Av 288-5527
Ryan Robt C
1526 W Jackson 282-2251
Schindel J H Inc
State Rd 67 N Albany 789-4454

Schussler H Tom
General Dentistry—By Appointment
2016 W McGalliard Rd 289-7233
Schussler H Tom
General Dentistry-By Appointment
4825 N Wheeling Av 289-7233
Simmonds James F St Rd 67 E Daleville 378-5790
Slavin Chas N 315 W Wash 282-2265
Slavin Charles P 315 W Wash 282-2265
Smith Garry L
1431 N Madison Av Suite 5 Anderson 649-3388
Taylor Jas A 610 S Tillotson Av 288-5541
Taylor Tyrel D 610 S Tillotson Av 288-5541
Thomas Harvey G
General Dentistry By Appointment
710 E Willard 282-4523
White Alan L
Hours By Appointment
8:30 AM to 4:30 PM Except Wednesday
Sat Until 11:30 AM
109 N Main Lynn 874-1400
Wilhoite John L
By Appointment Only
[Illegible] 289-6373

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 655]

October 26, 1976

Re: Chad Jester
Policy # 70186
Radiographic request of
Dr. James G. Pierce

Ms. Jackie Todd
Personnel Dept.
J. C. Penney Company
2101 St. Rd. 109 By-pass
Anderson, In.

Dear Ms. Todd:

The dentists of Anderson and Madison County, Indiana, are represented by the Indiana Federation of Dentists

It is the policy of the members of this union to make radiographs available, along with all diagnostic records, to any Indiana licensed dental consultant, in the office of the treating dentist.

If Equitable has such a consultant in this area, I will be glad to arrange an appointment for him to visit with Dr. Pierce and review his in office diagnostic records on this case.

The Federation is willing to assist Equitable in obtaining a local consultant who will work on a per case basis, if they do not have a consultant for the area.

Sincerely,

David B. McClure, D.D.S.
President

DBMcC/df

cc: James G. Pierce, D.D.S.

[FTC COMPLAINT COUNSEL'S TRIAL EXHIBIT CX 811 A, B]

PERCENTAGE AND NUMBER OF IFD MEMBERS REPRESENTED IN DENTAL SPECIALTIES LISTED IN TELEPHONE DIRECTORY COVERING MADISON COUNTY *

	No. Specialists	No. IFD MEMBERS	Percentage
All Specialties	10	10	100%
Individual Specialties			
Oral Surgery	3	3	100%
Orthodontics	3	3	100%
Pedodontics	2	2	100%
Periodontics	2	2	100%

SOURCE: Anderson, Indiana telephone directory, including nearby communities of Alexandria, Chesterfield-Daleville, Elwood, Frankton, Gaston, Lapel, Markleville, Mechanicsburg, Middletown, Muncie-Yorktown, Pendleton, Perskinsville and Summitville listed in the same telephone directory (March 1979 ed.).

* Figures exclude: dentists listed in Anderson telephone directory whose listed office address is outside Madison County; current IFD members listed in membership roster submitted by IFD (See CXID-18) and not listed in the Anderson telephone directory; and non-current and retired IFD members.

PERCENTAGE AND NUMBER OF IFD MEMBERS REPRESENTED IN DENTAL SPECIALTIES LISTED IN TELEPHONE DIRECTORY COVERING LAFAYETTE, INDIANA AREA *

	No. Specialists	No. IFD MEMBERS	Percentage
All Specialties	12	8	67%
Individual Specialties			
Oral Surgery	4	4	100%
Orthodontics	3	2	67%
Pedodontics	3	1	34%
Periodontics	2	1	50%

SOURCE: Lafayette/West Lafayette, Indiana telephone directory, including nearby communities of Battle Ground, Brookston, Clarks Hill, Mulberry, Otterbein, Romney, and West Point listed in the same telephone directory (December 1978 ed.).

* Figures exclude: dentists listed in Lafayette/West Lafayette telephone directory whose listed office address is outside the Lafayette/West Lafayette area; current IFD members listed in membership roster submitted by IFD (See CXID-20) and not listed in the Lafayette/West Lafayette telephone directory; and non-current and retired IFD members.

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 9, 9A-C]

STATE OF INDIANA

[SEAL]

INDIANAPOLIS
INDIANA STATE BOARD OF DENTAL EXAMINERS
700 North High Street Road
Indianapolis, Indiana 46224

January 19, 1979

TO ALL INDIANA DENTISTS:

In light of recent developments which involve the practice of dentistry in the State of Indiana, The Indiana State Board of Dental Examiners would like to take this opportunity to re-emphasize provisions of the Indiana Dental Act to the dentists of the State. Indiana Code 25-14-1-23 defines the practice of dentistry as:

> Any person shall be said to be practicing dentistry within the meaning of this chapter (25-14-1—25-14-1-29) who uses the word "dentist" or "dental surgeon" or the letters "D.D.S." or "D.M.D." or other letters or titles in connection with dentistry:
>
> or owns or operates a dental office or is manager or conductor of the same;
>
> or advertises or permits to be advertised by sign, card, circular, handbill, newspaper, radio, or otherwise that he can or will attempt to perform dental operations of any kind;
>
> or offers to diagnose or profess to diagnose or treats or professes to treat any of the lesions or diseases of the human oral cavity, teeth, gums, maxillary or mandibular structures;

> or extracts human teeth or corrects malpositions of the teeth or jaws;
>
> or administers denaal anesthetics, whether local or general;
>
> or makes X-ray pictures of the human teeth or jaws;
>
> or makes impressions or casts of any oral tissues or structures for the purpose of diagnosis or treatment thereof or for the construction, repair, reproduction or duplication of any prosthetic device to alleviate or cure any oral lesion or replace any lost oral structures, tissues, or teeth;
>
> or engaged (engages) in practices included in the curricula of recognized dental colleges;
>
> or directly or indirectly by any means or method furnishes, supplies, constructs, reproduces, repairs, or adjusts any prosthetic denture, bridge, appliance, or any other structure to be worn in the human mouth and delivers the same to any person other than the duly licensed dentist upon whose written work authorization the work was performed. Such written work authorization shall include: (1) The name and address of the dental laboratory to which it is directed; (2) the case identification; (3) a specification of the materials to be used; (4) a description of the work to be done, and, if necessary, diagrams thereof; (5) the date of its issuance; and (6) the signature and address of the licensed dentist or other dental practitioner by whom the work authorization is issued. A separate work authorization shall be issued for each patient of the issuing licensed dentist or other dental practitioner for whom dental technological work is to be performed;
>
> or who advertises to the public by any method to furnish, supply, construct, reproduce, repair, or adjust any prosthetic denture, bridge, appliance, or other structure to be worn in the human month;

Provided, That this section shall not apply to those procedures which a legally licensed and practicing dentist may delegate to competent office personnel as to which procedures the dentist exercises direct supervision and full responsibility which procedures shall in no event include either (1) *those procedures which require professional judgment and skill such as diagnosis and treatment planning* and the cutting of hard and/or soft tissues or any itraoral (intraoral) impression which would lead to the fabrication of an appliance, which, when worn by the patient, would come in direct contact with hard or soft tissues and which could result in tissue irritation or injury, or (2) those procedures allocated by IC 1971, 25-13-1-(25-13-1-1—25-13-1-19) the Dental Hygienist Act of Indiana to certified dental hygienists; Provided, further, That this chapter shall not prevent dental students from performing dental operations under the supervision of competent instructors within the dental school of a university recognized by the Indiana state board of dental examiners, or in any public clinic under the supervision of the authorized superintendent of such clinic authorized under the authority and general direction of the board of health or school board of any city or town in Indiana; Provided, further, That legally licensed pharmacists of this state may fill prescriptions of legally licensed dentists of this state for any drug necessary in the practice of dentistry.

Under Indiana law it is a Class B misdemeanor for a person to practice dentistry without a license, or to aid or abet another person in the practice of dentistry, in the State. Indiana Code 25-14-1-25 provides in part:

> (a) It is a Class B misdemeanor for a person to:
>
> (1) *practice dentistry not being at the time a dentist duly licensed to practice as such in this state under this chapter*; (2) *employ, hire, or procure one who is not duly licensed as a dentist to practice dentistry*, but a person practiced upon by an unlicensed dentist does not violate this section . . . . (Emphasis added).

Indiana Code 35-41-2-4, which defines the crime of aiding, inducing or causing an offense, posits:

> *A person who knowingly or intentionally aids, induces, or causes another person to commit an offense commits that offense*, even if the other person:
>
> (1) Has not been prosecuted for the offense;
>
> (2) Has not been convicted of the offense; or
>
> (3) Has been acquitted of the offense. (Emphasis added).

The criminal penalty for a Class B misdemeanor is stated in Indiana Code 35-50-3-3:

> A person who commits a Class B misdemeanor shall be imprisoned for a fixed term of not more than one hundred eighty (180) days; in addition, he may be fined not more than one thousand dollars ($1,000).

It has come to the attention of the Indiana State Board of Dental Examiners that many Indiana dentists have and are experiencing problems with insurance companies in relation to benefit determinations—especially in the matter of the submission of radiographs. It is the Board's position that no insurance clerk, who would be a layman, could possess the knowledge required to make a diagnosis from radiographs. Nor would such a clerk have the knowledge to determine whether a proposed treatment would be proper, so that it would fall within authorized bounds of an insurance policy. Pursuant to the above statutes, ONLY a licensed dentist should review radiographs and proposed treatments for third party insurance companies and the use of clerks to make such reviews is unlawful.

Dentists who knowingly submit radiographs, or other diagnostic data, to third persons, including insurance companies, that allow persons other than licensed dentists to review such data, are aiding or abetting in the unlawful practice of dentistry. Those dentists are subject to criminal penalties (as cited above in IC 25-14-1-25), and to revocation or suspension of their license.

The Indiana State Board of Dental Examiners requests and expects the cooperation of all licensed Indiana dentists to prevent the unlawful practice of dentistry in the State. If individual dentists have any complaints of, or information of, unlawful practice of dentistry, the complaint or information should be forwarded in writing to the Board office.

Respectfully submitted:

/s/ Paul A. Stephens, D.D.S.
PAUL A. STEPHENS, D.D.S.
President

/s/ F. A. Duncan, D.D.S.
FRANK A. DUNCAN, JR., D.D.S.
Secretary

/s! Richard Newton, D.D.S.
RICHARD T. NEWTON, D.D.S.
Vice-President

/s/ John W. Sandlewick, D.D.S.
JOHN W. SANDLEWICK, D.D.S.

/s/ M. Gilbert Eberhart
M. GILBERT EBERHART D.D.S.

/s/ Edward L. Fritz, D.D.S.
EDWARD L. FRITZ, D.D.S.

/s/ Richard C. Harris, D.D.S.
RICHARD C. HARRIS, D.D.S.

/s/ Raymond L. Dennany
RAYMOND L. DENNANY, D.D.S.

/s/ Everett L. Ringenberg D.D.S.
EVERETT L. RINGENBERG D.D.S.

cc: All Indiana Dentists
H. Pete Hudson, Indiana Insurance Commissioner
Indiana Dental Association
Indiana Federation of Dentists
Theodore L. Sendak, Attorney General,
Attention: Jane M. Gootee, Deputy

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 30]

May 19, 1975

MEMORANDUM

To: D. I. Chichester—29

From: J. Chernyha—38

Re: Indiana Dental Association

Thank you for the copy of your May 14 memo to Fred Roberts. Although I don't quite understand all the details (I have not seen the material you are referring to), I don't have any problems with it.

All I know is that so far everybody (GM, UAW, CG, and the dentists) has been happy with our performance and results. I want to be sure that we don't do anything to change this regardless of what our friendly competitors might or might not be doing. We must always remember October 1, 1976.

/s/ JC
jdm

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 31, 31 A]

September 3, 1975
Dave Chichester—29

R. E. Caffray—29
Dental Consultants—Indiana

On August 28, 1975, I visited the Indiana Dental Claim Office and discussed with Fred Roberts some areas of claim cost control to find out how he and his dental consultants were handling them, I also talked to Dr. Mishler and Dr. Beavers. I was quite impressed with their efforts and wanted to make a report to you.

1. *Gold vs. Amalgam*—About 35% of the cases include x-rays. If their dental consultant would do the case with amalgam rather than gold, they allow only the usual cost of amalgam. Many cases include a narrative, and the dental consultant makes the same type of judgment as he would with x-rays. If there is no narrative, they request either a narrative or x-rays.

2. *Bridgework*—They normally allow bridgework over partials except in the case of a long span. The member and location of the missing teeth play a big role here. They are very insistant on complete charting of teeth on the claim form and are able to do a lot with this information.

3. *Crowning of Teeth*—They require a full explanation of the need for crowns on all anterior (front) teeth or when there are multiple crowns. They normally do not allow crowns on abutment teeth to partial dentures unless there is evidence of need. If they are needed they are allowed at 50% unless the tooth is broken down and needs a crown in its own right. Then it is at 85%.

4. *Prognosis*—This is a tough area to control without x-rays. Their approach is to have the dental consultant phone the dentist on certain cases. Cases involving splinting and peridontal treatment are normally given close screening. The dental consultants find most dentist quite open in discussing the prognosis.

5. *Peer Review and Independent Exams*—They have not submitted any cases to Peer Review, nor have they found it necessary to have an examination of a claimant at this time.

Fred related to me some of the reasons that he felt helped his average claim payment stay low.

a. The dentists in Indiana are more conservative in the nature of their practice. There are about 2,000 dentist in the state, and Fred's office will process about 200,000 claims this year. Yet, he sees only about ten claims a week that run over $2,000. They don't do that much exotic dentistry. Patients are not that willing to take on very expensive treatment plans due to their portion of the co-insurance.

b. The amount that Fred considers as reasonable and customary also plays a big role. While he tries to keep at about the 90th percentile, he feels that over all his allowances are less than some of the other offices.

c. His administration of some of the limitations is stricter than other offices in some instances. Without x-rays he will often deny benefits unless the dentist can justify the need.

6. *Professional Relations*—We both agreed that we should try to keep a fairly low profile in Indiana and that there is no need for any formal program or meetings. Fred can handle the Indiana Bell professional meetings. He does plan to meet sometime in

the future with Kentucky dentists as he is starting to get some dental business on non-union coal mines in Kentucky.

In summary, I was quite impressed with their efforts and feel that they have a good handle on things. What they lose by not always getting x-rays, they are making up for by demanding more complete charting on the claim form, narrative reports, and direct phone conversation with the attending dentist. I am forwarding a copy of this report to Fred in case he wishes to add to it.

dmf

cc: Fred Roberts

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 33]

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

MEMORANDUM

Date September 7, 1976

To Dave Chichester

From Bob Caffrey

Subject Indiana

You will recall the recent memo recording that a union has been found amongst the dentists in Indiana in the Anderson area. Dr. David McClure is heading up this union. I talked to John Speziale about this situation, and he says that this does not present any problem to CG. The dentists in Anderson are working quite well with CG, and the union was developed mainly because of a fear of General Motors; not CG. There was some thought that there was a fear that Connecticut General may exercise its clout.

John is sending me copies of newspaper articles that appeared in the Anderson area. One article attacks the insurance industry. John followed up with phone calls to Dr. Pierce and Dr. McClure. As a result of these phone calls, a follow-up article was published indicating that the dentists were not having trouble with CG, and that their relationship was good with CG. I will forward these copies to you when they arrive.

John visited the major General Motors location in Anderson to discuss this particular subject with them. They indicated that they would support Connecticut General all the way. John feels that he has convinced them, however, to let him handle the situation. At this time, I feel John has the situation well under control.

kk

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 43 A]

LIST OF EQUITABLE EMPLOYEES AUTHORIZED TO SCREEN X-RAYS FOR THE DENTAL CONSULTANT

(AUGUST 1, 1975 THROUGH APRIL 13, 1979)

		AGE	EDUCATION
1.	Gloria Caruthers	29	High School
2.	Michelle Cordeau	26	College Degree
3.	Diane (Parker) Hovan	27	High School
4.	Gloria Lawton	34	High School
5.	Delane Williams	25	High School-Dental Assistant
6.	Kathy Smith	36	College Degree
7.	Frances Sarlea	32	High School
8.	John Kos	33	College Degree
9.	William Robinson	34	College Degree
10.	Joel Miller	32	College Degree
11.	Charles Madison	32	College Degree
12.	Brent VanVleck	32	College Degree
13.	E. Scott Ray, Jr.	32	College Degree
14.	Carol McIntosh	27	High School

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 96, 96 A]

THE DEPARTMENT OF INSURANCE
509 State Office Building

January 20, 1972

Mr. William G. Downes, III, D.D.S.
Manager, Dental Administration
151 Farmington Avenue
Hartford, Connecticut 06115

Re: Complaint File 71-5197

Dear Mr. Downes:

I regret that you were unable to attend the meeting on January 12. Since the Dental Association members had already scheduled this meeting, they wanted to come in nevertheless and express their viewpoints on this urgent problem.

You will find attached a copy of the points that were discussed at this meeting and also a letter dated January 17 which specifically lists all the members that were present and summarizes the overall position of the Indiana Dental Association. I am also attaching a Xerox copy of the Illinois Dental Service letter dated November 18 which is referred to in the previous material.

I wish to make a few observations of my own based upon the information revealed at this meeting:

1. It appears that Aetna may have accepted a lower rate for this dental coverage in order to obtain the whole group.
2. It appears that Aetna is paying claims with no friction on other group plans in this state and the points of elimination such as the X-Rays and the prepayment features have not manifested

themselves in complaints to our department in your handling of these claims.

It seems to me that if you can live with the Indiana Dental Association guidelines and official position on other plans, then obviously the reason you cannot accept this same course of conduct in dealing with the International Harvestor group is that you bid the rate too low and, therefore, you are trying to skip every dollar of claim so that your loss in this dental contract can be minimized.

These dentists will be glad to take time off again to arrange for a new conference in our department if you will just set the date that is agreeable with you so that there will be no cancellation of your appearance again. Any Wednesday date in February is acceptable except February 16 because there is a dental convention on that date. I am also willing to include Wednesday, March 1. This gives you four Wednesday dates.

Please pick one, and I will notify everyone so that a proper delegation can be present at this new meeting. It may be that your position might change in the meantime in view of my comments. If so, we will be happy to hear from you.

Yours very truly,

/s/ Michael D. Saldino
MICHAEL D. SALDINO
Deputy Commissioner
Director, Complaint Division

MDS/lw

cc: Mr. J. Michael Quinn

Attachments

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 167]

STATE OF INDIANA
INDIANAPOLIS, 46204

OTIS R. BOWEN, M.D.
GOVERNOR

HOSEA P. HUDSON, Commissioner
THE DEPARTMENT OF INSURANCE
509 State Office Building

BULLETIN 37
SUBJECT: DENTAL X-RAYS

The Department has previously advised insurance companies offering *dental insurance plans* that the practice of allowing personnel not licensed as dentists to evaluate dental x-rays is a violation of the insurance laws of Indiana governing Unfair Trade Practices and the Indiana Dental Licensing law (I.C. 25-14-1-1 et seq.). Notwithstanding that companies have been so advised, allegations are being made that certain insurance companies are currently utilizing personnel not licensed as dentists to evaluate dental x-rays.

This Department reiterates and reaffirms its position opposing such practice. Evidence brought to my attention reflecting this conduct will result in an unfair trade practice hearing against the company so charged.

/s/ H. P. Hudson
H. P. HUDSON
Commissioner

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 500 A, B]

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CONFIDENTIAL

IT IS INTENDED FOR THE USE OF
AETNA LIFE & CASUALTY PERSONNEL *ONLY*

UNAUTHORIZED USE IS PROHIBITED

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DENTAL EXPENSE BENEFITS
INTERPRETATIONS & CONTROLS

Date: May, 1977

LIFE & HEALTH
CLAIM GUIDE V

There are several methods for determining if misrepresentation has occurred. Before any steps are taken, the file should be reviewed by the supervisor and the dental consultant to ensure that there is no error:

1. Post-operative X-rays can be obtained to show satisfactory completition of the work. These are not conclusive evidence one way or the other, since the wrong X-rays can be submitted.
2. Oral exams by outside dentists are the best method of determining what work has been performed. In cases involving large amounts, it may be helpful to request the examining dentist to take X-rays as a record of any discrepancies. It might also be wise to duplicate the pre-operative X-rays before returning them to the attending dentist.
3. In a few instances, a claim representative may examine the dentist's record. The method should be used judiciously and only for the purpose of verifying dates of treatment and if duplicate services were rendered.

   Once misrepresentation has been established and the amount of overpayment determined, efforts should be made for recovery. Refer to Processing Section, Administration for letters to be used when fraud or misrepresentation has been clearly shown.

Do not send them unless you have adequate proof. Post-operative X-rays alone are not sufficient, and an oral exam should be used as a follow-up when fraud is suspected.

In all dealings with either claimants or dentists, it is important not to accuse anyone without adequate proof. Mistakes can easily be made in completing a claim form, and every effort should be made to rule this out. No action, other than the letters shown in the Administration Section, should be taken without referral to H.O.

VII. REVIEW OF X-RAYS

In reviewing X-rays, claims personnel, as lay persons, can only expect to see where teeth are missing, to identify impacted teeth (but not the degree of impaction), malposed teeth, supernumerary teeth, mixed dentition, extensive caries, existing restorations, some forms of abscesses, and in some cases, evidence of need for orthodontics. IT REQUIRES A PROFESSIONAL CONSULTANT TO READ AND INTERPRET X-RAYS FOR OTHER THAN THE MOST EVIDENT CONDITION.

[INTERVENOR STATE OF INDIANA TRIAL EXHIBIT IX 1000 E, F]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

No. IP 79-453-C

STATE OF INDIANA; and
INDIANA STATE BOARD OF DENTAL EXAMINERS

vs.

THE UNITED STATES OF AMERICA;
FEDERAL TRADE COMMISSION; and
MICHAEL PERTSCHUK, Chairman,
PAUL RAND DIXON,
ELIZABETH HANFORD DOLE,
DAVID A. CLANTON, and
ROBERT PITOFSKY,
Members of Federal Trade Commission

ENTRY

The matters of the defendants' September 7, 1979 motion to vacate nunc pro tunc certain findings of fact and conclusions of law to conform to modified judgment as amended on October 9, 1979 to show belated service of motion on plaintiffs' counsel, and plaintiffs' motion to strike came on for the Court's ruling.

The Court having considered the matters and being duly advised in the premises, now finds that defendants' motion should be and is hereby DENIED and plaintiffs' motion to strike is MOOTED by such ruling.

Simultaneously herewith the Court if filing a CORRECTED judgment entry of August 17, 1979.

It is apparent that the Federal Trade Commission has jurisdiction over certain of the matters and of the Indiana licensed dentists before it. On the other hand that jurisdiction is limited by the exclusive rights of the State of Indiana under the police power to protect the health of the citizens of Indiana and oversee the dental profession. It is this right that the defendants are enjoined from invading and impressing upon the State of Indiana's citizens of an agreed course of conduct between a group of dentists and the Federal Trade Commission in which the State of Indiana had no input. The agreement between the Federal Trade Commission and one group of Indiana dentists no doubt will be in issue in the hearing of the complaint in Docket No. 9118. Indiana's ability to prosecute a dentist would be greatly hampered by such a course of agreed action. The power of the purse of the payers acting through unlicensed, incompetent personnel could be the ultimate deciding factor in the diagnosis of an Indiana citizen's need for dental care. It should be clear that the mission of the Federal Trade Commission is not limited to the complainant payers' and Indiana's licensed dentists points of view but also respect the rights of the sovereign State of Indiana and thus avoid complainant payers' and/or Indiana's licensed dentists use of the Federal Trade Commission proceeding to circumvent the State of Indiana's policing the dental profession in the interest of the health of its five million citizens. The Federal Trade Commission is unhampered by this Court's ruling of August 17, 1979 in fulfilling its mission in Docket No. 9118. The findings of facts as found and the conclusions of law thereon are necessary for the relief sought.

Dated this 18 day of October, 1979.

/s/ Cale J. Holder
CALE J. HOLDER
Judge,
United States District Court
Southern District of Indiana

• • • •

[IFD'S TRIAL BRIEF, 9/20/79]

[22] From the submitted evidence, it does appear that the insurers have continued to operate much the same since their programs were initiated. No changes are alleged because of Respondent or any of its members. The amount of claims and amount paid on claims has apparently increased over the years. This pattern was expected by the industry and has apparently occurred as expected and because of inflation, familiarity with insurance plans, and other external factors. Respondent or its members have no affect on these factors.

Complainant has submitted documents purporting to show that premiums paid by customers of the insureds also flow across state lines. It is noted that that allegation is not a part of the Complaint. In any event no evidence has been propounded that any activity by Respondent or its members has affected that flow of funds. If the purpose of all the information submitted by Complainant is to imply that the cost of insurance has increased because of any activity by Respondent or its members, no such connection has been made. Further, it is unfortunate that the presence of insurance should directly affect the cost of any dental procedure. But, that is precisely what must happen if Complainant is successful in this action. The insurers have shown consistent gains in profits, i.e., surplus of premiums over claims. Those profits are gained as a result of reducing service to patients and subjecting patients to judgments made by non-professionals or professionals who use less than the necessary diagnostic aids. The "profits structures" of the insurers is not the interstate commerce with which we are dealing in the instant case.

D. *Reasonableness and Fairness:*

Much has been written elsewhere in this brief showing the reasonableness and fairness of Respondent's alleged conduct. Duplication hereafter will be avoided.

The FTCA was not intended to reach every remote adverse affect on competition. *Universal Rundle Corporation v.s. Federal Trade Commission*, 382 F. 2d. 285 (1967). Placing conditions upon sending X-Rays to a claims adjuster or another dentist who will not avail himself of diagnostic information required by state law and sound professional standards would hardly seem to qualify as unfair under the test set by the courts and the FTC in the leading cases, *Sperry & Hutchinson Company v.s. Federal Trade Commission, supra; Spiegal, Inc. v.s. Federal Trade Commission, supra.*

While the insurer or payer may obviously find it beneficial to their private interest to have the Federal Trade Commission force dentists to furnish them X-Rays and diagnostic aids, the FTCA was passed for the protection of the public and not the insurance company experts. *Aronberg v.s. Federal Trade Commission*, 132 F. 2d. 165 (1942); *United States v.s. Hilton Hotels Corporation*, 467 F. 2d. 1000 (1972).

Prosecution of the Complaint in the instant case is contrary to the very standards upon which the FTC is founded. By this Complaint the FTC is taking sides in what is primarily a private conflict. By this Complaint the FTC is forsaking the real public policy of protecting the consumer and forcing the concerted private methods of competing insurance companies upon a public and a professtion that are ill equipped to protect themselves against these large profit oriented companies. By this Complaint, the FTC is Acting Contrary to the very policies of the United States, as directed by the President, that recognize that X-Rays are in the nature of diagnostic tools and not to be used as a routine screening tool in the absence of prior clinical evaluation *Memorandum of Understanding, Radiation Protection Guidance To Federal Agencies For Diagnostic X-Rays*, Federal Register, Vol. 43, No. 22—Wednesday, February 1, 1978. In the July 17, 1979, Federal Register, the Food and Drug Administration, United State of America, has made the

following recommendation discouraging carriers from requiring post-treatment dental radiographs.

> (the) decisions to perform dental Ex-Ray examinations should be made by the patient's dentist. (the FDA is recommending) that dental radiographs not be taken solely for monitoring dental treatment claims for reimbursement by insurance carriers. This practice constitutes a source of unnecessary radiation exposure to the population. . . .
>
> Moreover, it can be argued that some other means of claims verification, such as *randon spot-checking of patients* by an individual dentist for the insurance carrier, is a more effective approach to detecting false claims or of assessing poor dental care. (Emphasis Added.)

Finally, by this Complaint theFTC is proceeding on speculation and misinformation.

Complainant chooses to elevate the "cost-containment" methods above the activities of a profession to assure sound diagnosis. It is a nationally known fact, as reported by Mr. Barry Bosworth, Director the President's Council on Wage and Price Stability, when he stated "dentists are the professional group which has the smallest increase in fees." Dental expenses have in fact decreased substantially since 1950 as a percentage of total health care costs and have remained nearly stationary as a percentage of individual personal income. At the same time, the quality of dental care has risen to the highest level. The existing total picture of a free and open market—quality, low cost, service, and public health—has been obtained prior to the evolution of this desire or need alleged by Complainant herein to require Respondent and its members to accede to the Cost Control programs of payers. These goals of a free market were obtained in the area of dental health long before the advent of the insurance programs. No patients have complained! They

are the public! It is their interests that have paramount consideration.

The Complainant has no basis upon which to conclude that the cost containment of the insurers is either entitled to special protection by the FTC or in fact effective. In *Group Life and Health Insurance Co., v.s. Royal Drug Company, Inc.*, 99 S. Ct. 1067(1979), the Supreme Court made it quite clear that the cost containment activities of insurance companies are not protected from anti-trust challenge. Yet, the Complainant's evidence shows irrefutably that the insurers have acted in concert to enforce these procedures upon all dentists and their patients. The evidence offered by Complainant no where refutes the fact that these cost containment activities of insurers are directed at suppression of services and not the cost of dental services. It is clear that the costs saved are primarily for the benefit of the insurers in the form of additional profits. It is clear from the evidence that the additional administrative costs of the insurers, when added to the additional costs transferred to the dentists, may well be as much or more than it is speculated may be saved by repressing services.

Complainant's evidence nowhere supports their conclusion that costs of insurance are affected by Respondent's alleged conduct. Insurers apparently have not lowered premiums while their profits have climbed. Reducing the administrative costs to the dentist, however, can be a savings passed directly to the patient. The cost of dental insurance in Indiana appears to be right in the middle of the national figures.

Even insurers have admitted their mistake of requesting too many X-Rays. Some companies request none. Others have reduced their demands. The need of dental consultants who are practicing the in the community has become recognized as beneficial because of the way practice varies with the locality. Arms length examination of any diagnostic aid by either dentists or laymen without such local knowledge and personal knowledge of the

patient is against public policy as well as against state law. Such insufficient diagnosis submits the patient to errors in judgment that places too great a risk upon his dental health. He should not have to bear that risk because of the concerted methods of competition among insurance companies. The radiation risk and the fact that radiographs can only reflect two dimensions of a three dimensional object place further unreasonable risks upon the patient.

Finally, improper diagnosis will place long term expense upon the patient. "Least expensive adequate" treatment is not designed to consider the attitudes of the patient and is not preventative in nature. Invoking such alternate course of treatment is an arbitrary decision of the insurer which causes the patient to receive less benefits than he may otherwise be entitled. Such stop-gap measures not only cause delays in treatment, but discourages the patient from seeking quality dental care. The consumer is no match for the coercive requirements of the insurer.

The policy of Respondent as criticized by the FTC primarily serves to promote public welfare. At the same time, its competitive significance is remote. Further, it is in conformity with direct State Legislation. Respondents' policy in no way impedes the ordinary give and take of the market place. In reverse, to implement the desire of the FTC expressed in the Complaint herein will promote only the purpose of insurers, will have great impact on the setting of prices nation wide, will cause higher costs, will directly interfere with the competition among dentists and the public, is contrary to the public policy as recognized by the President, will force patients to choose only dentists that fully"cooperate" with payers, and will require dentists and their patients to submit to coercive measures and treatment against their interests under the guise of the internal cost control desires of a particular business. If it is indeed true that the "purpose of the analysis is to form a judgment about the sig-

nificance of the restraint" on competition, as set forth in *National Society of Professional Engineers v.s. U.S., supra*, the implementation of the policies required by Complainant will result in the real restraint on competition and at the same time be contrary to public interest.

VI. *Conclusion*:

The evidence fails to support and justify the Complaint. The law is also against the Complainant. The findings herein should be against the Complainant and for the Respondent.

Respectfully Submitted,

/s/ Ronald K. Fowler
RONALD K. FOWLER
Attorney for Respondent

[PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF COUNSEL SUPPORTING THE COMPLAINT, 9/21/79]

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CONCLUSIONS

Effects

[112] The acts and practices found above have had, or have the tendency and capacity to have, the following effects among others:

1. Consumers, employers and dental insurers have been deprived of actual and potential benefits of third-party payers' cost-containment measures.

2. Competition has been hindered and restrained in the following respects, among others:

a. Dentists in Indiana, and especially in the Madison County and Lafayette, Indiana areas, have not competed with each other with respect to furnishing X-rays and other services to insurers whose plans cover their patients;

b. Consumers have been deprived of information in advance of receiving dental services which could be useful to them in deciding whether to purchase services from their existing dentist or a competing dentist;

c. Shifts in patients between competing dentists have been hindered;

d. Consumers have been limited in their opportunity to select dentists willing to cooperate with insurance company cost-containment measures;

e. Dental insurers have been pressured to change their business operations rather than make their decisions on the basis of competitive forces and cost efficiencies.

Law

1. The Federal Trade Commission has jurisdiction over the respondent and over the subject matter of this proceeding.

2. The respondent is a "corporation" within the meaning of Section 4 of the Federal Trade Commission Act.

3. The challenged acts, practices and methods of competition of respondent is in, and affects, commerce within the meaning of the Federal Trade Commission Act.

4. Respondent, Indiana Federation of Dentists, has combined and conspired with the Indiana Dental Association and its members and has combined and conspired with its own members to frustrate cost-containment provisions in dental insurance plans, by among other means, inducing dentists not to submit X-rays used for claims determination and by inducing insurance companies to appoint and use dental consultants in the manner prescribed by respondent and the Indiana Dental Association.

5. The above conduct has hindered, restricted, restrained, foreclosed and frustrated competition and caused substantial injury to the public.

6. The aforesaid concerted acts, practices and methods of competition engaged in by respondent constitute unfair methods of competition and unfair acts or practices in or affecting commerce • • •

• • • •

[STATE OF INDIANA'S TRIAL BRIEF, 9/24/79]

• • • •

[6] Further, IFD members at no time conspired among themselves to withhold x-rays. The IFD Work Rule is merely a promulgation of a total diagnosis concept which is universally accepted as proper dental technique. This Work Rule does not proscribe the sending of x-rays to third parties, and in fact, some dentists within IFD do submit x-rays.

The vast majority of FTC documentary evidence concerns IDA activity. Unfortunately, this IDA evidence bears no relevance to IFD activities. The mere allegation of an IDA-IFD conspiracy is totally inadequate in and of itself to render the IDA documents relevant. The conspiracy theory is interesting, but untenable when confronted by the facts.

Unfair Competition and Unfair Practices

Complaint counsel maintains that the acts of IFD constitute a *per se* violation of Federal law. However, the test applied in *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), indicates that agreements constituting *per se* violations are those:

> . . . whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality.

This test shows on its face that the instant case cannot constitute a *per se* violation. The instant case requires an elaborate study of *both* the dental industry and the insurance industry so as to glean an alleged violation in the first instance. The submission or non-submission of x-rays cannot possibly be so anti-competitive that its effects are plainly visible. The converse, in fact, may be true. *Assuming* that a percentage of dentists in a particular area do not submit insurance x-rays, it is only reasonable, and foreseeable, that the remaining dentists

who *do* supply x-rays will have a competitive edge when seeking insurance related business. Thus, the actual effect may be pro-competitive. The actual effect on competition simply cannot be determined without an industry-wide study. Especially when a learned profession is involved. Even in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), which complaint counsel relys so heavily upon, the Court stated quite explicitly:

> The fact that a restraint operates upon a profession as distinguished from a business is *of course* relevant in determining whether that particular restraint violates the Sherman Act. It would be *unrealistic* to view the practice of professions as interchangeable with other business activities, and automatically to apply to the profession antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated *differently. We intimate no view or any other situation than the one with which we are confronted today.*' (Emphasis supplied.)

The *Goldfarb* case, as did the *Professional Engineers* case, involved an obvious price control scheme which was enforced through various channels. The instant case makes no allegation of enforcement of submission policies. The instant case alleges frustration of cost control, but the actual effect on the cost of dental service cannot be ascertained without an evaluation of *both* insurance cases, *and* ultimate total care costs. Thus, a rule of reason case is obviously what must result. As *Professional Engineers*, (*supra*), clearly states, agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the alleged restraint, and the reasons why it was imposed, must of necessity be subject to a rule of reason analysis. Such is the present situation.

In a very recent case involving a group of Anesthesiologists, the Court in *United States v. The American Society of Anesthesiologists, Inc.*, —— F.Supp. —— (S.D. N.Y., 1979), found that alleged price fixing and alleged anti-competitive conduct must be treated under a rule of reason analysis, as the unique industry had to be analyzed to determine actual effect. In a set of facts similar to the present case, the Court ultimately found that promulgation of a suggested methodology (such as the IFD Work Rule) for arriving at appropriate fees, did not constitute an agreement to adhere to a pricing formula, nor did it constitute any concrete anti-competitive effect on the *market for anesthesia services.* Surely, the present case demands a rule of reason analysis.

The FTC further seeks to protect the interests of consumers by alleging that IFD has engaged in "unfair or deceptive practices." This catchall allegation overlooks the purpose for which the section was enacted. The Court in *F.T.C. v. Sperry & Hutchinson Co.*, 405 U.S. 233 (1972) indicated that it is the *consumer interests* which are the key to definition of "unfair or deceptive practices." It is therefore interesting that the consumer has been given so little attention in the present case.

The insurance companies appear to be the object of the FTC's interest. Although the theory is that lower insurance bills will mean lower premiums to consumers, this has yet to be shown. The issue of quality dental care for consumers appears to be of little importance to the FTC in this case. The State and the IFD, however, believe in and adhere to quality dental care, and it is, therefore, the IFD and the State who are acting in the interests of the consumer.

Boycott

Group boycotts are "concerted refusals by *traders* to deal with other *traders*," Klors v. Broadway-Hale Stores, 359 U.S. 207, 212 (1959), or may be combinations of

businessmen "to deprive others of access to merchandise which the latter wished to sell to the public," *United States v. General Motors Corp.*, 384 U.S. 127, 146 (1966). In *Smith v. Pro Football, Inc.*, 593 F.2d 1183 (1978), the court held that a group boycott means actual boycott of a *competitor.* It is difficult to visualize how insurance companies are competitors with dentists, and therefore, it is difficult to envision how a boycott may result. * * *

* * * *

[IFD'S APPEAL BRIEF TO COMMISSION, 5/29/80]

* * * *

IV.

ARGUMENT

A.

THAT THE ALLEGED CONDUCT OF RESPONDENT IS NOT PER SE AN UNREASONABLE RESTRAINT OF TRADE

[5] The Administrative Law Judge concludes that the actions of IFD constitute a *per se* unlawful restraint of trade pursuant to 15 U.S.C. 1, and 15 U.S.C. 45. (Initial Decision, paragraph 122.) The Law Judge cites, as authority for this conclusion, well defined and classic competitor/buyer-seller relationships as explained in cases such as *Klors Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1958). The cases cited in paragraph 120 of the Initial Decision all involve well defined instances of economic boycotts. The instant case does not fall within the confines of the authority cited for the conclusion of a *per se* violation. The Law Judge concedes in paragraph 122 that there is *technically* neither a competitor nor a buyer/seller relationship between boycotters (IFD) and boycottees (insurers) *but*:

> there are *similar economic relationships susceptible to abuse.* The *insurers broadly represent the economic interest of the dentists patients* and to that end *need access to the patients' x-rays* for cost-containment purposes. . . (emphasis added) Initial Decision, paragraph 122.

This quoted paragraph from the Initial Decision cites to no authority, evidence, or fact. It is purely a conclusive statement, and yet a statement vital to the finding of a

per se violation. The simple test applied in *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978) indicates that agreements constituting *per se* violations are those:

> . . . whose nature and necessary effect are so plainly anti-competitive that no elaborate study of the industry is needed to establish their illegality.

The instant case requires an elaborate study of both the dental profession and the insurance industry so as to glean a violation of any kind. Instead, the Law Judge found a *per se* violation based upon at least three totally unsupported conclusions:

1. That there are similar (as to *Klors*, *supra*) economic relationships susceptible to abuse;

2. That insurers broadly represent the economic interest of the dentist's patients;

3. That Insurers need access to patient's x-rays for cost-containment pruposes. *See* Initial Decision, paragraph 122. The conclusion that a *per se* violation has occurred is therefore unsupported, if not flawed. The U.S. Supreme Court recently stated in *Broadcast Music, Inc. v. CBS*, 441 U.S. 1 (1979) that:

> it is only after considerable experience with certain business relationships that courts classify them as *per se* violations. *See United States v. Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972).

The business relationships in the instant case are between the recently enacted dental insurance programs (Tr. 987, 388, 391, 1140, 1611, 1659) and the age old profession of dentistry. Surely, the Law Judge did not have considerable experience with *these* relationships. Indeed, the instant case involved unique and novel relationships which must be analyzed in terms of their actual effect on competition and trade. The effect of respondent's conduct *must* be assessed in this case. The

effect of respondent's conduct is not so plainly anticompetitive that it can be labeled *per se* unlawful. Evidence of this can be gleaned from the total absence of evidence in the Initial Decision of anticompetitive effects of respondent's conduct. The Initial Decision fails completely to deal with the essential question of whether the so-called boycott by the IFD members, had any restraining effect on competition anywhere.

Further, the Law Judge agrees that "neither IFD nor any dentist member stands in the relation of competitor to any insurer." *Initial Decision*, paragraph 122. In his haste to conclude a *per se* violation, the Law Judge relies solely upon *St. Paul Fire and Marine Inc. Co. v. Barry*, 438 U.S. 531 (1978). [At least that case was decided subsequent to *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).]

* * * *

B.

[14] THAT UNDER THE RULE OF REASON THE PRO-COMPETITIVE EFFECT OR BENEFICIAL EFFECT OF RESPONDENT'S ALLEGED CONDUCT ON HEALTH AND SAFETY OUTWEIGHS ANY ANTICOMPETITIVE OR ANTI-CONSUMER EFFECTS

The foregoing section underscores the necessity for application of a Rule of Reason analysis in the instant case. Clearly, the instant case involved a learned profession and is thus significantly distinguished from an ordinary business. In *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), the Court stated quite explicitly:

> The fact that a restraint operates upon a profession as distinguished from a business is *of course* relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the profession antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated *differently. We intimate no view or any other situation than the one with which we are confronted today.* (Emphasis added)

The Law Judge realizes in paragraph 123 of the Initial Decision that different antitrust rules apply to the professions. The Law Judge then engages in an after the fact balancing test so as to determine if the *anti-competitive* factors created by respondent are outweighed by other considerations. Initial Decision, paragraph 125. Unfortunately, the alleged anti-competitive factors of respondent are not indicated in the Initial Decision. Without a delineation of these "alleged" anti-competitive factors of respondent no worthwhile balancing can occur. Indeed, the Court of Appeals, Second Circuit, in *C.B.S. v. A.S.C.P.A.* Docket No. 75-7600 (No. 120, 4/3/80), held that under the Rule of Reason analysis, the complained of action must be shown to be *anti-competitive* before any antitrust violation is made out. The Court in *C.B.S.* dismissed an antitrust suit because no showing of *anti-competitive* effect was demonstrated. Clearly, no showing of anti-competitive effect of respondent's conduct has been established in the Initial Decision, and thus any references to such "alleged" anti-competitive factors are *unsupported* (e.g. Initial Decision paragraph 125). Further, the Law Judge concludes that respondent "shut off" insurer's access to x-rays and thus organized an unlawful economic squeeze play. (Initial Decision, paragraph 122) Footnote 337 of the Initial Decision (page 89) defines the allegedly unlawful shut off:

337 "Shut off" is not too strong a term under the circumstances here. It is true that most dentists have typically expressed their willingness to let insurers' "qualified" experts come to their (the dentists') offices to look at x-rays and other diagnostic aids, (CX 99W). However, there is abundant testimony in this record that that is an empty offer because it *is not economically feasible* for the insurers to send experts around to each dentists's office (Tr 341-42, 924-25, 978, 1121, 1232, 1383-84,
* * *

* * * *

[23] * * * (Tr. 321, 2685, 2686, 2705, 2687, 2688.) The Honorable Cale Holder, Judge of the United States District Court, Southern District of Indiana, construed Indiana law so as to proscribe the lay reading of x-rays. (IX-1000). *False Conclusion No. 5*: In Paragraph 159 of his Findings of Fact, the Law Judge concludes it is difficult to see how an insured can ever be prejudiced, since the para-professional can only allow claims. First, it is undisputed that x-ray submission is expensive and that x-rays are not usually necessary. Thus, extra costs are incurred even in routine payment. Second, it was not disputed that pre-determination does take time. Thus a patient may lose treatment time. Third, it is undisputed that even a professionl should not make diagnosis without a clinical examination (Tr. 2692, 945, 2716) and yet, where alternate benefits are invoked without patient examination, treatment is *reduced* in the vast majority of the cases. (Tr. 625. 915, 520, 1397, 1430, 1507) Finally, like the Federal Trade Commission Act, State Laws designed to protect public health are intended to be prospective and preventative. The Indiana State Legislature long ago recognized the need to prevent harm that would occur to a patient when treatment was based upon less than a first hand diagnosis by a dentist without all data available. (Tr. 945, 2716, 2692) The evidence in this case was overwhelming on the fact that the

"Work Rule" of respondent was true (Tr. 318, 319, 2695, 2433, 2434) and that x-rays have many limitations and are a "limited diagnostic tool." (Tr. 1220) To adopt the philosophy espoused by the Administrative Law Judge herein requires that the State of Indiana and its dentists make patients "guinea pigs" to standards determined by big insurers for purely economic motives. It is foolish and unreasonable to tinker with long standing legislation and dental practices that have so well protected the health of the people of the State of Indiana. Such legislation has long been upheld. *Gibson v. Berryhill*, 411 U.S. 564 (1973); *North Dakota Board of Pharmacy v. Snyder's Drug Stores, Inc.*, 414 U.S. 156 (1973), *Williamson v. Lee Optical*, 348 U.S. 483 (1955); *Olsen v. Smith*, 195 U.S. 332 (1904).

Respondent's alleged conduct, its "Work Rule" ethic, and Indiana Dental Law promote competition among dentists as well as benefit the consumer (patient). In addition to the other herein discussed consumer benefits and consumer protecting purposes, the alleged conduct of respondent promotes competition among dentists. Certainly promoted are novel means of competiing concepts of dental care, such as employer or union organized clinics. Compeition is natuarlly promoted among dentists who treat only after total diagnosis, in that their total treatment plan will be more successful from both a preventative viewpoint and long term maintenance of oral health. Error is less likely, thus reducing needed corrective work. Proper diagnosis will promote proper services, and satisfied patients will patronize those dentists. Dentists who are not members of respondent, will naturally get favorable treatment from insurers, unions, and employees with whom they may contract or cooperate in any manner they choose, so long as it is within the confines of State law. Peer review is promoted, but only proper professional standards will be involved. A second opinion must be as professionally based as the opinion

of the treating dentist. Certainly, no one suggests that peer review is suspect. Further, the "phenomenal" growth of dental care plans in Indiana, and their increased profits, is clear evidence that they have enjoyed a healthy economic climate. Indeed, analysis under the Rule of Reason reveals no antitrust violation of respondent.

* * * *

[IFD'S REPLY BRIEF TO COMMISSION, 7/17/80]

* * * *

INTRODUCTION

[1] Many of the arguments advanced in the Answering Brief of Counsel supporting the Complaint are directly refuted and briefed in Respondent's Appeal Brief and will not be repeated herein. The following reply brief is therefore not intended to again respond to all points raised by Complaint counsel, and Respondent does not explicitly or implicitly accept, or agree with, Complaint Counsel's proffered arguments by its decision to not reargue them herein. This brief will be divided into three (3) sections, as follows:

PER SE ANALYSIS

Complain counsel accurately states that "the challenged conduct here is not a classic group boycott designed to exclude competitors," and implicity suggests that the Commission should "consider the challenged boycott under a rule of reason analysis." (ABC at 29). However, Complaint Counsel thereafter attempts to catagorize Respondent's conduct as a *per se* violation (ABC at 27) in accord with the Initial Decision (I.D. 122). The Administrative Law Judge (ALJ) conceded in the Initial Decision that there is technically neither a competitor nor a buyer/seller relationship between boycotters (IFD) and boycottees (insurers) (I.D. 122) but:

> there are *similar economic relationships susceptible to abuse.* The *insurers broadly represent the economic interest of the dentists patients* and to that end *need access to the patients' x-rays* for cost-containment purposes . . . (emphasis added) (I.D. paragraph 122)

This quoted paragraph cited to no authority, evidence, or fact. Ostensibly, Complaint Counsel now wish to advance

yet another theory to fill the gap (created in paragraph 122) by asserting that "insurance companies simply act as the patient's agent." (ABC. at 27). The insurance company as the real payor in interest (so the argument goes) assumes a substantial commercial relationship with the dentist that is not unlike a buyer-seller relationship. (ABC. at 27, no authority cited, other than paragraph 122). Since paragraph 122 is a vital link to the finding of a *per se* violation (R. 5) it is small wonder why Complaint Counsel attempt to "shore up" the unfounded conclusion contained therein. Unfortunately, Complaint Counsel offer no evidentiary citation, and indeed, no such evidentiary foundation exists. (ABC. at 27). Consequently, the assertion "similar economic relationships subject to abuse" (I.D. ¶ 122), constitutes nothing more than a theory. The Court in *Boise Cascade Corp. v. FTC*, 1980-2 Trade Cases (63, 323, 9th Cir. 1980) stated that more than a mere theory of the likely effect of challenged practices must be advanced to demonstate a *per se* violation of section 5 of the Federal Trade Commission Act (FTCA) 15 U.S.C. § 45.

Additionally, Complaint Counsel argues that *per se* disposition may be appropriate where anticompetitive effects are clearly defined. (ABC at 28). Respondent notes that this argument was not advanced or supported by the ALJ in the Initial Decision (ID ¶ 120-122) and is raised *sua sponte* by Complaint Counsel. Whereas the Initial Decision frames the issues on this appeal, as well as the findings, such argument is not within the purview of this appeal.

RULE OF REASON ANALYSIS

Complaint Counsel implicitly asserts, and quite correctly, that a Rule of Reason analysis must be utilized. (ABC at 29) However, Complaint Counsel erroneously asserts that traditional antitrust rules should apply to the instant case wherein a *medical* profession is involved. (ABC at 29-30). Apparently, insurers should be able to

make their "business decisions [solely] on the basis of competitive forces and cost efficiencies as a free market would dictate," (ABC at 23) irrespective of whatever horrible health hazards may result. The U. S. Supreme Court in *Goldfarb v. Virginia State Bar*, * * *

* * * *

[IFD'S REPLY BRIEF TO COMMISSION]

* * * *

[5] * * * programs which do *not* require x-rays (or the use of predetermination or alternate benefits) are the fastest growing in utilization and popularity, raises serious doubts as to the necessity of dental x-rays. (Tr. 1080) It thus appears that insurers in the instant case have unilaterally decided (for monetary reasons (ABC 24)) to request x-rays, despite the adverse health effects. The mere fact that time and money would be required to establish an alternate procedure to the challenged x-ray procedure, does not render the actions of IFD anti-competitive. *CBS v. ASCAP*, Docket No. 75-7600 (No. 120, 4/3/80). (R. 15-16).

Aside from the important health consideration presented in this cuase (R. 53-55) there are procompetitive effects of IFD activities. First, alternate and competitive dental insurance programs are growing in popularity and use. (Tr. 1089) Bill Payer Plans have been promoted and offered as competitive alternatives. (Tr. 2636, 2649) Dentists offering quality total diagnosis dental care obtain a competitive edge over other dentists. (Tr. 2402) (Patients desirous of x-ray submission seek out complying dentists (Tr. 2601) thus promoting novel insurance oriented dental clinics (CX-76-F). In short, the health considerations and procompetitive aspects of IFD's conduct outweighs any speculative and theoretical * * *

* * * *

[IFD'S BRIEF BEFORE 7TH CIRCUIT, JUNE 30, 1983]

* * * *

[23] * * * "we have thus forsigned 95% of the practicing dentists in Madison County". (CX 484B) [Ap 355] With respect to Chapter 2 the Commission quotes an IFD newsletter stating that "all but a few dentists in our four (4) county area are now members of the federation." (CX 549A, FO p 28) [Ap 372, 195] However, this figure was taken from a Chapter 2 Indiana Federation of Dentists newsletter obviously designed to elicit membership in the IFD. (CX 549A-D) [372-75] The Commission thereafter concludes that "even though the actual total membership of IFD was small, its market power in some localities was clear from its effect on the behavior of insurers and the functioning of the dentist-insurer relationship." (FO p 28, 29) [Ap 195-6] There is no indication in the Final Order of the alleged market power of Chapter 3 of IFD.

Agency findings of fact must be based on substantial record evidence. *Snap On Tools v. F.T.C.* 321 F.2d 825 (7th Cir., 1963). It would seem that a reliable indication of IFD market strength must be obtained by computing the percentage of IFD members in a local market area. The record indicates that as of June, 1979 there were at least sixty six (66) dentists in Madison County, Indiana. (R 2261) [Ap 684] and at least sixty nine (69) dentists listed in the Anderson area phone book (CX 612 [Ap 379-81]. Further, the Commission's own evidence indicated forty six (46) IFD members in the Anderson-Madison County area. (CX 18A-B) [Ap 263-64] These figures demonstrate that IFD market power in Chapter 1 is between 66 and 69 percent. As of June, 1979 there were forty six (46) dentists in Tippecanoe County alone. (R 2261) [Ap 684] There were between 23 and 25 IFD members in Chapter 2. (CX 19, CX 20) [Ap. 265-69] This demonstrates a 50 to 56% IFD market power in

Chapter 2.[5] Allen County, Indiana contained 139 dentists as of June, 1979 (R2261) [Ap 684] of which 19 belonged to the IFD. (CX 21) [Ap 270] This demonstrates at 13% IFD market power in Chapter 3. The above figures may be generously high considering the number of dentists located in towns outside of the various Chapter areas.[6] Even assuming that IFD had attained some degree of market power in the local areas of its Chapters the Commission failed to consider the critical question of whether IFD dentists compete amongst each other as to their policy of dealing with third party payer insurance companies. Absent a showing of competition in this market, an anticompetitive effect thereon cannot be demonstrated. It would, at the very least, seem incumbent upon the Commission to demonstrate that the number of non-IFD members in a local market cannot accommodate covered consumer-patients seeking out non-IFD members. No attempt was made by the Commission to demonstrate this effect. At least one non-IFD member (CX 18) [Ap 263-64], Dr. Robert Vladoiu, *advertised* in the Anderson, Indiana area phone book (CX 612B) * * *

* * * *

[5] This figure does not include non-IFD members in Clinton, White, and Carroll counties; counties included in Chapter 2. (CX 15A) [Ap 249]

[6] For example, Muncie, Indiana is 17 miles from Anderson, but outside of Madison County. (R 2465) [Ap 734]

[FTC'S BRIEF BEFORE 7TH CIRCUIT, AUGUST 31, 1983]

* * * *

[34] IFD argues first that the Commission "decided that the relevant market was 'competition among dentists as to their policy of dealing with third-party payers' " (Pet. Br. 21);[26] then argues that "the Commission must first prove that IFD dentists compete in their dealings with third-party payers, before there may be a finding that such competition is affected" (*id.* at 22); and concludes that "the Commission fail[ed] to establish competition among dentists with respect to their dealings with third-party payers" (*id.* at 25).[27]

We have noted that this argument is not properly before the Court (n.19, *supra*). Moreover, it does not advance IFD's position. The Commission's case concerns

[26] IFD's characterization of the "market" misses the point. Any fair reading of the Commission's opinion shows that the Commission focused upon a market that consists of dental services and competition among dentists in the offering of dental services (App. 168, 170, 171, 196, 207). When the Commission concluded that "[s]uch concerted activity by competitors resulted in reducing or eliminating competition among dentists as to their policy of dealing with third party payers" (App. 196), the Commission was merely describing the particular aspect of the dental services market that has been injured by IFD's activities.

[27] The Commission also found that "under IDA's leadership, the conspiracy spanned many, if not most localities in Indiana [and u]nder the leadership of IFD, it continued to be strong in the local areas covered by that organization's three chapters" (App. 196). Although IFD grouses at the brevity of the Commission's geographic market discussion (Pet. Br. 21), it does not actually challenge the correctness of the Commission's finding on this point. Indeed IFD itself observes that "it most probably may be presumed that dentists in a local area compete for local patients in general" (*id.*). Appellate courts have frequently sustained findings of anticompetitive effects in numerous local markets in cases challenging the conduct of national trade associations. *E.g., American Medical Ass'n* v. *FTC, supra; National Society of Professional Engineers* v. *United States, supra.*

IFD's role in a concerted refusal by Indiana dentists to submit x-rays to insurers. Absent the agreement, each dentist would have decided individually on the terms and conditions on which he or she would offer dental services and deal with patients and insurers (App. 195, 196). Although IFD complains that the record does not show that dentists have ever competed among themselves in submitting x-rays to insurers (Pet. Br. 22), such argument ignores that the conspiracy has existed almost since the time group dental insurance policies were first offered in the early 1970's (App. 760). If the record does fail to establish competition among dentists with respect to their dealings with dental insurers that failure is itself eloquent testimony of the success of the IFD and IDA conspiracy. The absence of such competition, far from negating the existence of a demand for such competition, rather reinforces other evidence showing a conspiracy to prevent it (see pp. 8-13, *supra*).[28]

IFD also argues that the Commission's finding of an anti-competitive effect is negated by evidence suggesting IFD's market power is less than that found by the Commission. Specifically, IFD directly challenges the Commission's reference to IFD's own statement that its membership included nearly 95 per cent of the practicing dentists in Madison County and "all but a few dentists" in the four counties comprising Chapter II. IFD argues that only 66 to 69 per cent of the dentists in Madison County were members, 50 to 56 per cent of the eligible dentists were members of Chapter II; and 13 percent were members of * * *

* * * *

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[28] IFD acknowledges that dentists may be presumed to compete with each other "in general" (Pet. Br. 21).

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PETITIONER'S

BRIEF

No. 84-1809

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1985

FEDERAL TRADE COMMISSION, PETITIONER

v.

INDIANA FEDERATION OF DENTISTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE FEDERAL TRADE COMMISSION

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QUESTION PRESENTED

Whether the court of appeals misapplied the "substantial evidence" standard of review and this Court's precedents regarding analysis of horizontal restraints of trade in vacating an order of the Federal Trade Commission that prohibits dentists from conspiring to boycott insurance company cost containment programs, where the court of appeals erroneously concluded that the dentists' conspiracy constituted mere collective adherence to an established "legal, moral, and ethical" policy to promote "quality dental care."

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BRIEF FOR THE FEDERAL TRADE COMMISSION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-50a) is reported at 745 F.2d 1124. The opinion and order of the Federal Trade Commission (Pet. App. 54a-112a) and the decision of the administrative law judge (Pet. App. 118a-283a) are reported at 101 F.T.C. 57. The Commission's order denying respondent's petition for reconsideration (Pet. App. 113a-117a) is reported at 101 F.T.C. 718.

JURISDICTION

The judgment of the court of appeals (Pet. App. 51a) was entered on October 11, 1984. A petition for rehearing was denied on December 21, 1984 (Pet.

App. 52a-53a). The time within which to file a petition for a writ of certiorari was extended to and including May 20, 1985. The petition was filed on May 17, 1985, and was granted on October 15, 1985. The jurisdiction of this Court rests upon 28 U.S.C. 1254(1).

STATUTE INVOLVED

Pertinent portions of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, are set forth at Pet. App. 284a-288a.

STATEMENT

A. Background—Dental Health Insurance Cost Containment

This case involves a conspiracy by Indiana dentists to withhold x-rays that were sought by insurance companies in order to review effectively dental insurance claims and eliminate unnecessary charges for dental services.

Industrial dental health care insurance policies became widely available to consumers in the early 1970s pursuant to collective bargaining agreements between major employers and labor unions.[1] In response to corporate employers' pressure to keep insurance premiums as low as possible, unions' demands that fringe benefit dollars paid by employers not be consumed disproportionately by health insurance payments, and insurers' own interest in reducing expenses and premiums, dental insurers have developed various techniques to help contain the rising cost of dental care (Pet. App. 86a, 139a; J.A. 20, 25, 36-38).

One approach, used both in Indiana and throughout the country, is a contract provision limiting benefit payments to the cost of the "least expensive yet adequate treatment" (Pet. App. 139a n.25, 140a; J.A. 20-21).[2] If a dental patient desires a more expensive treatment, the additional cost must be paid by the patient; it is not covered by insurance benefits (Pet. App. 241a).[3] In order to determine the benefits to which a patient is entitled under such an "alternate benefit" provision, insurance companies must evaluate the treatment furnished (or proposed to be furnished)[4] by dentists to insured patients. Insurers

[1] By 1978, dental insurance, primarily multi-state group health insurance plans underwritten by corporate employers, covered 48 million people nationwide (Pet. App. 139a n.22) and at least 1.5 million persons in Indiana (J.A. 107). The evidence in this case concerns dental insurance covering employees of the International Harvester Company, provided by Aetna Life and Casualty Co.; employees of the General Motors Corporation, provided by Connecticut General Life Insurance Co.; and employees of the Brockway Glass Co., provided by Metropolitan Life Insurance Company (Pet. App. 6a-7a, 83a-84a).

[2] Such a provision is often called an "alternate [or alternative] benefits" clause (Pet. App. 61a n.4, 140a).

[3] For example, a patient may elect to purchase an enamel crown for cosmetic purposes, even if a less expensive gold crown would suffice to remedy the patient's medical problem. In addition, many dental procedures are elective in nature and even those that are not may necessitate choices based upon cost. J.A. 20-21, 24-25, 29-31, 50-51.

[4] When an expensive course of treatment is involved, insurers prefer to review the proposed treatment and advise the dentist and patient of the benefits that will be paid under the policy. This "predetermination" of benefits allows the patient to decide how much, if any, of the planned treatment will be covered by the insurer. Although predetermination is encouraged by insurers, it is not generally required as a condition of payment. Pet. App. 61a-62a n.4, 158a n.76.

accordingly request dentists to submit with the completed claim form copies of available pre-treatment dental radiographs (x-rays)[5] and other relevant information. Pet. App. 61a-62a n.4; J.A. 2-3, 22-24.

Insurers use dental x-rays to help screen out the great majority of clearly justified claims from the small percentage of claims warranting further scrutiny (J.A. 22-25, 30-32).[6] The claim forms, x-rays, and any other proffered information are reviewed initially by lay examiners, who are authorized to approve claims but not to deny them (Pet. App. 92a). If a lay examiner questions any claim, he or she refers the matter to the insurer's dental consultant, who is a licensed dentist (*id.* at 247a). The dental consultant, after considering whatever additional information is deemed relevant in the exercise of the consultant's professional judgment, then recommends that the insurer either grant the claim, deny it, or agree to pay only the cost of an "alternate benefit".[7] Before recommending the denial of a claim or the

[5] In many situations involving major dental treatment, dentists use pre-treatment x-rays in making a diagnosis (*e.g.*, J.A. 2). The record contains no evidence that insurers have insisted upon submission of x-rays in a case in which the dentist had not taken x-rays prior to treatment.

[6] Examination of the patient's x-rays can verify the existence of many dental problems (Pet. App. 235a-236a) and dental health insurance plans therefore use x-rays as an important part of their claims evaluation process (see *id.* at 240a). In Indiana, the impetus for requesting dentists to submit x-rays came not only from individual insurers, but also from employers and unions interested in controlling the costs of dental health insurance (*id.* at 86a, 200a).

[7] Although the alternate benefit usually is less costly than the treatment originally proposed, it occasionally is more costly (Pet. App. 140a n.26).

payment of an alternate benefit, a dental consultant generally contacts the treating dentist to discuss the proposed treatment and the patient's condition. J.A. 18-19, 21-23, 29-30.

During 1976 and 1977 insurers made over $13 million in payments to, or on behalf of, Indiana consumers under dental insurance plans containing alternate benefits provisions (Pet. App. 149a). The record in this case discloses no instance in which any insured patient was injured or threatened with injury, or in which a patient received less than adequate dental treatment, because of any insurer's cost containment measures (*id.* at 91a-92a).

B. IDA, IFD, And Their Boycott

The Indiana Dental Association (IDA), whose membership accounted for 85% of Indiana's dentists during the period relevant to this case, viewed insurers' cost containment programs as a threat to the economic welfare of dentists and an unwarranted intrusion into the dentist-patient relationship (Pet. App. 78a-80a). In a 1974 speech to IDA's Council on Dental Care Programs, Dr. David McClure, then Secretary of IDA and the future first president of the Indiana Federation of Dentists, explained (Pet. App. 80a; J.A. 104):

> We are fighting an economic war where the very survival of our profession is at stake. * * * The name of the game is money. The government and labor are determined to reduce the cost of the dental health dollar at the expense of the dentist. There is no way a dental service can be rendered cheaper when the third party has to have its share of the dollar.

IDA and its member dentists undertook a concerted campaign to thwart insurers' cost containment measures, engaging in a collective refusal to submit x-rays to insurers for claims review (Pet. App. 152a-172a). A key ingredient in the campaign was a highly successful drive to secure written pledges of adherence to IDA's "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care," which provided that dental care plans should not require dentists to submit x-rays to third parties (J.A. 88); and acceptance of the more specific IDA policy against sending x-rays to insurers (Pet. App. 78a-80a, 156a-170a).

From the boycott's inception, its leaders recognized that concerted action was necessary to defeat insurers' cost-containment efforts. Without a unified front, dentists who refused to submit x-rays might lose patients covered by dental insurance programs to dentists who cooperated with insurers (see pp. 29-30, *infra*). IDA's appeal for concerted action was successful, and by early 1975, "most Indiana dentists were not only agreeing in theory but following in practice [IDA's] plan to boycott insurers" (Pet. App. 175a; see also J.A. 97-99).

Following this Court's decision in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), IDA's enthusiasm for the boycott flagged (Pet. App. 207a-209a). Concern over antitrust liability was the principal factor that prompted certain IDA leaders from the Anderson, Indiana, area to form the Indiana Federation of Dentists (IFD) in 1976 (*id.* at 70a, 152a, 211a; J.A. 106, 109). IFD and its members continued the IDA boycott under the misapprehension that their self-styled status as the "nation's first union of private practice dentists" (J.A. 106) would confer "unquestioned immunity" and free them from "the antitrust albatros[s] around our neck" (Pet. App. 213a; J.A. 109-110).[8]

The leaders of the new organization believed that their mandate was to intensify the IDA boycott campaign (Pet. App. 70a-71a). In a report to IDA's Board of Trustees on IFD's formation (*id.* at 215a; J.A. 114), IFD's first President explained:

> [A]bout 80-90% of dentist [*sic*] practices in the Anderson area [IFD headquarters] is covered by one insurance carrier; therefore, the dentists there believe they need more muscle than organized dentistry can give them. They found that via a union they could go beyond dental association activities. In their opinion the union movement will not weaken the IDA but will supplement it.

IFD clearly was founded for economic reasons. Its "Constitution and By-Laws" states that IFD exists "[to] represent dentists in all socio-economic matters, negotiations and grievances with employers, third, and fourth parties or any group that is involved in financing or delivery of dental care" and "[t]o seek to insure adequate compensation and proper working

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[8] IFD, in fact, is not and has never been a bona fide "labor organization" within the meaning of Sections 6 and 20 of the Clayton Act, 15 U.S.C. 17 and 29 U.S.C. 52 (see Pet. App. 146a), and IFD has abandoned any contention that its self-described status as a labor union exempts its conduct in any way from the FTC Act (cf. *id.* at 65a n.7). IFD also has abandoned any contention that its status as an organization of professionals entitles it to exemption under Section 4 of the FTC Act, 15 U.S.C. 44, which defines "corporation," as used elsewhere in the Act, to mean any "company * * * or association * * * organized to carry on business for its own profit or that of its members" (see Pet. App. 65a n.7, 275a).

conditions for dentists" (Pet. App. 216a; J.A. 58). IFD's credo, incorporated into its charter, recites that "only in and through a united effort can we be assured of receiving full and just compensation and due appreciation for our services" (Pet. App. 211a).

To achieve IFD's economic goals, the Constitution and By-Laws authorizes "strikes, job actions, boycotts, or other forms of economic pressure" (Pet. App. 217a; J.A. 59), and discipline of IFD members by censure, fines, suspension, or expulsion for "any action detrimental to the welfare of the organization" (Pet. App. 217a; J.A. 62-63). IFD's Executive Committee also has considered the circumstances under which IFD will seek (although "only as a last resort") to "discipline, or [undertake] acts of reprisal against, non-member dentists and dissident members" (Pet. App. 220a; J.A. 120).

Immediately after its formation, IFD began its campaign to further the boycott. At the association's first annual meeting the full membership adopted the IFD Work Rule (Pet. App. 22a, 82a-83a, 217a-218a), which provides, in pertinent part (*id.* at 218a; J.A. 123):

> The patient's dentist * * * has a moral and legal responsibility to not allow a determination of his patient's condition to be made for any purpose, without benefit of a complete examination.

The rule barred IFD members from sending dental x-rays to insurers who requested x-rays in connection with benefit determinations (Pet. App. 82a-83a, 89a-90a, 218a). IFD's Executive Board directed that the Work Rule be printed on the back of a claim form that IFD provided to its members. The claim form, together with a standard letter designed by

IFD, was used by IFD members in refusing to submit x-rays to dental insurers. IFD members offered instead to provide insurers with "all diagnostic aids," including x-rays (and an opportunity to examine the patient), if the insurer would send its licensed dental consultant to the treating dentist's office. *Id.* at 24a, 71a-72a, 218a.

IFD established chapters in and around three Indiana communities: Anderson (Madison County), Lafayette, and Fort Wayne (Pet. App. 8a). Each of these towns is the site of a plant employing workers insured under a dental health care plan (*id.* at 177a, 188a; J.A. 125), and IFD was highly successful in recruiting members in these communities. As of September 1976, IFD's Chapter I secretary reported that nearly 95% of all practicing dentists in Madison County had joined IFD, while the Chapter II (Lafayette) newsletter reported in September 1977 that "[a]ll but a few dentists in our four county area are now members of the Federation" (Pet. App. 84a-85a; J.A. 124).[9]

C. Impact Of The Boycott

A majority of Indiana dentists joined the IDA/IFD boycott; as a result, competition among dentists with respect to submission of x-rays to insurers was substantially eliminated. The flow of x-rays to insurers narrowed to a trickle in certain localities and the few dentists submitting x-rays did so covertly for fear of reprisals by the organizations. Because insurers were denied information they required in or-

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[9] IFD's Chapter III, encompassing Allen County (Fort Wayne), gained adherents more slowly, growing to 13% of the county's practicing dentists by June 1979, one year after it was founded (Tr. 220, 2261; CX 21).

der to substantiate claims, some claims were paid late, or not at all, and the insurers' efforts to contain costs by paying only for reasonable care were thwarted. Pet. App. 85a-86a, 95a-96a. For example:

1. Within one year after the campaign began, Aetna Insurance Company (Aetna) had accumulated a backlog of 600 unpaid claims because it was unable to verify allowable benefits (Pet. App. 83a, 180a). In a one-time attempt to eliminate the backlog, Aetna, at substantial expense, sent its dental consultant—a licensed dentist—to the office of each dentist who had refused to submit x-rays with insurance claims (*id.* at 83a, 181a). The consultant, who subsequently was admonished and threatened with sanctions by IDA officials for urging cooperation with Aetna,[16] reviewed the claims with the individual dentists and encouraged them to submit x-rays in the future (*ibid.*).

Many dentists responded that they did not dare submit x-rays; others simply refused (Pet. App. 83a, 179a). In the face of the continuing boycott, Aetna ultimately was forced to conduct examinations of claimants in its Fort Wayne office (*id.* at 83a-84a, 187a-188a). Between 1974 and 1978 Aetna conducted nearly 4700 examinations at a then-estimated expense of $10 apiece (*id.* at 84a, 87a-88a) and an unquantifiable expense and inconvenience to patients required to undergo a second examination.

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[16] The dentist was warned that he "would place [himself] in a position of being censored [*sic*]" if he continued to urge his fellow dentists to submit x-rays. Fearing criticism of his objectivity and a charge of breach of ethics by his peers, the dentist eventually terminated his relationship with Aetna. Pet. App. 183a-187a.

2. Connecticut General Insurance Company (Connecticut General) suffered similar experiences in attempting to administer its group dental policy covering General Motors' employees (Pet. App. 84a, 188a-203a). Between autumn 1974 and spring 1976, Connecticut General received one per cent "if that many" of the x-rays it requested from dentists in the Madison County area (J.A. 13). In 1973 and 1974 Connecticut General officials met several times with IDA officials—including the future president of IFD—in an attempt to reach an accord regarding the submission of dental x-rays (Pet. App. 189a-190a). Connecticut General was informed, however, that "Indiana dentists have a definite and unified position with regard to the use of x-rays" (*id.* at 192a (emphasis omitted)). In order to conduct some sort of claims review, the company finally entered into a "cumbersome, time-consuming, expensive, unsupervisable arrangement" for the review of claims in Madison County (*id.* at 201a (footnote omitted); J.A. 4-10). Under this arrangement, insurance claims were referred to a local dentist recommended by IDA. This dentist worked out of his local office because claims could not be processed in Connecticut General's Indianapolis claims review office in the absence of the submission of x-rays (*id.* at 84a, 200a-203a).

The arrangement Connecticut General worked out with the Madison County dentists was "absolutely unique" (J.A. 6), and would have been prohibitively expensive had the company been forced to use a similar arrangement over a wider area (Pet. App. 202a n.237; J.A. 6-7). In January 1977, Connecticut General's Indianapolis office manager again requested the submission of x-rays in an attempt to determine whether the position of Madison County dentists had

softened. IFD promptly dispatched a three-man delegation to Connecticut General to reiterate in forceful terms its unified opposition to x-ray submission. As a result, Connecticut General abandoned all efforts to obtain x-rays from Madison County dentists. J.A. 15-17.

3. The conspiracy also affected Madison County employees of Brockway Glass Company (Brockway). The company's representatives met in January 1977 with officials of IFD to request that x-rays be submitted to Metropolitan Life Insurance Company so that benefits could be paid under Brockway's dental insurance plan; the insurer had refused to pay claims that were not supported by appropriate x-rays. IFD's representatives advised Brockway that IFD had been formed to place "leverage" on employers, and that IFD members would not submit x-rays. After this meeting, Brockway's employees continued to suffer denial of benefits under the group dental policy. Direct appeals by Brockway to individual members of the dentists' conspiracy failed to secure the submission of x-rays. Pet. App. 84a, 225a; J.A. 33-35.

D. Proceedings Below

1. Proceedings Before The Commission

In October 1978, the Commission issued an administrative complaint against IFD, alleging that its boycott constituted an "unfair method of competition" in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.[11] The matter was

[11] IDA was named a co-conspirator in the complaint, but was not a respondent in the FTC proceeding because it previously had consented to entry of a cease and desist order pro-

assigned to an administrative law judge (ALJ) who presided over an evidentiary hearing.

a. On March 24, 1980, the ALJ issued his initial decision, finding that IFD had conspired with others in restraint of trade by engaging in a boycott to deny x-rays requested by dental insurers (Pet. App. 118a-283a). The ALJ determined that the IFD-led conspiracy among competitors constituted a per se violation of the antitrust laws (*id.* at 276a). He also determined, after analyzing the competitive effects and IFD's proffered justifications under the rule of reason, that IFD's conduct had substantially injured competition (*ibid.*). Finally, the ALJ concluded that the state action doctrine did not exempt IFD from antitrust liability (*ibid.*). Finding that IFD had been conceived "simply as a 'labor union' *front* for those IDA members * * * who were most concerned with keeping IDA's boycott of dental health insurers alive, even after antitrust prosecution began to loom as a real threat" (*id.* at 278a-279a (emphasis in original)), the ALJ issued a cease and desist order directing, inter alia, the dissolution of IFD (*id.* at 282a-283a).

b. IFD appealed the ALJ's decision to the full Commission, which rendered its decision and order on February 17, 1983 (Pet. App. 54a-112a). The Commission noted that concerted conduct among horizontal competitors frequently has been held to be a per se violation of Section 1 of the Sherman Act, 15 U.S.C. 1. It concluded, however, that IFD's boycott should be analyzed under the rule of reason because, among other things, the Commission wished to con-

hibiting the continuation of its boycott activities and the repetition of similar conduct (Pet. App. 11a n.6).

sider the procompetitive benefits, if any, related to the ethical and public service justifications advanced by IFD in support of its conduct (*id.* at 76a-77a).

The Commission then examined the "nature, purpose and effect on competition" of IFD's restrictions (Pet. App. 78a). The Commission noted that the boycott had the effect of "reducing or eliminating competition among dentists as to their policy of dealing with third-party payers" so that patients covered by dental health care plans of the type involved here "found it difficult to purchase care from dentists who would satisfy the terms of their coverage" (*id.* at 85a). Without a conspiracy, the Commission observed, individual dentists would have been subject to competitive market forces, creating incentives for them to cooperate with the requests of patients' third-party insurers (*ibid.*). However, "[b]y colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate" (*ibid.*). The boycott thus "reduced consumer choice" and "impaired insurance companies' ability to conduct cost-containment programs" (*id.* at 95a), with the final victim being "the patient policyholder who lost the value of his insurance company's efforts to contain costs" (*id.* at 86a).

Against these concerns, the Commission considered IFD's principal contention at trial, that " 'under the rule of reason the pro-competitive or beneficial effect of [its] alleged conduct on health and safety, outweighs any anticompetitive or anti-consumer effects' " (Pet. App. 73a, quoting IFD's Appeal Brief to Commission 4). The Commission held (Pet. App. 90a-92a) that IFD had not shown that the boycott had procompetitive effects and had not

substantiated the purported health and safety justifications for its conduct. The Commission stated that "[n]ot a single instance has been cited where any dentist agreed to provide less-than-adequate treatment because of the fear of an erroneous insurance determination" (*id.* at 91a-92a) and that "IFD has presented no evidence to even suggest that these restraints were necessary to serve any legitimate procompetitive purpose" (*id.* at 95a-96a).[12]

The Commission also rejected IFD's claim that the boycott did not harm competition because insurers could review x-rays by visiting dentists' offices, finding that "the record is clear that this was prohibitively expensive" (Pet. App. 88a). It further held that the effectiveness of x-ray review by insurers as a cost containment measure is irrelevant in assessing the anticompetitive effect of the boycott. The Commission stated that "[a]n antitrust violation cannot be justified on the grounds that it sought to remedy a poor business decision by the targets of the boycott. It is enough that the restraint is shown to have significantly distorted the competitive process" (*ibid.*).

Finally, the Commission rejected IFD's contention that its conduct was immune from liability under the state action doctrine, noting that "Indiana law does not affirmatively express any policy in favor of collusion among dentists in order to prevent * * * the use of x-rays by insurance companies" (Pet. App. 98a-99a). The Commission also observed that IFD had

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[12] The Commission rejected IFD's arguments that there was insufficient evidence to establish the required effect on interstate commerce (Pet. App. 64a-69a), and that the evidence did not demonstrate the existence of a conspiracy among IDA, IFD, and IFD's members to withhold x-rays from insurers (*id.* at 70a-72a).

not demonstrated that its anticompetitive conduct was supervised by state authorities (*ibid.*).[13]

Having found a violation of Section 5, the Commission issued a cease-and-desist order against IFD (Pet. App. 54a-57a). The Commission deleted the ALJ's proposed dissolution requirement, noting that while "IFD was created primarily to continue the implementation of IDA's boycott of dental insurers" its members might wish to pursue lawful functions "through the vehicle of a special organization such as IFD" (*id.* at 109a). After filing a petition for rehearing, which the Commission denied (*id.* at 113a-117a), IFD petitioned the court of appeals for review of the Commission's order.

2. *The Court Of Appeals' Decision*

The court of appeals held that the Commission failed to establish that the IFD boycott was unlawful under the rule of reason because the Commission did not show that the boycott had an anticompetitive effect (Pet. App. 2a). Repeatedly characterizing IFD's collective refusal to submit x-rays as the product of a "legal, moral, and ethical" policy to achieve "quality and proper dental care," the majority held there was "no substantial evidence" to support the Commission's findings that dentists compete with one another in dealing with insurers and that such competition had been harmed by IFD's actions (*id.* at 38a-44a).

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[13] The Commission did not make a determination regarding the boycott's effect upon competition in the dental insurance market (Pet. App. 86a-87a), and, having found the boycott to be an "unfair method of competition," it declined to address the question whether IFD's boycott also constituted an "unfair act or practice" prohibited by the Federal Trade Commission Act (*id.* at 96a-97a).

The court rejected as insufficient to establish the required anticompetitive effect evidence showing that most Indiana dentists participated in the boycott through IDA (Pet. App. 6a) and that 95% of all dentists in the Anderson area, and all but a few in the Lafayette area, joined IFD and implemented its policies (*id.* at 40a). The court found instead that because IFD member dentists continued to treat patients covered by group dental plans and invited insurers to review diagnostic aids in the treating dentists' office, competition was not harmed (*id.* at 42a-43a). The court also observed that "neither the ALJ nor the Commission found that the submission of a patient's dental x-rays actually lowered the insurer's dental costs" (*id.* at 41a), and that, in any event, the extra expenses imposed by the boycott had affected only "insurers in their review of dental claims" rather than "dentists in their competition for patients" (*id.* at 43a).

The court concluded that the Commission's finding of an antitrust violation amounted to a "rubber-stamp approval of the group dental health care insurers' practices" (Pet. App. 44a). It asserted that by challenging the boycott, the Commission was "preventing dentists from joining together to promote standards of quality dental care" and, "with absolutely no expertise or training in the highly advanced field of dentistry," was "unwisely regulat[ing] the dental profession and all of its specialties, including endodontia, exodontia, oral surgery, orthodontia, pedodontia, periodontia, and prosthodontia, to the detriment of consumers" (*ibid.*). Although the court cited no evidence to show that cost containment programs reduce the quality of dental care, it stated that "insurers cannot be permitted to forsake standards of quality and

proper dental care in an attempt to lower their dental costs" (*ibid.*).[14]

Senior Judge Fairchild concurred in the result (Pet. App. 45a-50a), although he subsequently voted to grant the Commission's petition for rehearing (*id.* at 52a-53a). He expressly rejected the majority's repeated assertions that the concerted refusal to submit x-rays was based on "legal, moral, and ethical" considerations. He accepted instead the Commission's summary of evidence showing that an express motivation for the boycott was economic (*id.* at 49a-50a). Judge Fairchild stated that he joined the majority in vacating the Commission's order only because the Commission had not shown that "a dentist's policy of refusal or cooperation [with insurers] has any significance in competition among dentists" (*id.* at 49a). The Commission's petition for rehearing was denied, with Judges Cudahy, Eschbach, and Posner voting to grant the suggestion for rehearing en banc and Senior Judge Fairchild voting to grant rehearing by the panel (Pet. App. 52a-53a).

SUMMARY OF ARGUMENT

The rapidly rising cost of health care is among today's most serious economic problems. Because third-party insurers typically defray all or part of the expense of treatment, and consumers thus do not pay directly for each service rendered, consumers may lack incentive to scrutinize both the necessity and the cost of particular treatments. This circumstance tends to increase overall costs, and, inevitably, insurance premiums, to the ultimate detriment of consumers.

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[14] The court did not address the "state action" defense raised by IFD (Pet. App. 45a n.18).

Employers and employee unions, the authorized bargaining agents for the employees/consumers who were the beneficiaries of the Indiana group dental insurance policies relevant in this case, were sufficiently concerned about rising health insurance costs to insist upon the use by insurers of the cost containment measures that became the subject of the Indiana dentists' boycott. The Federal Trade Commission, in a unanimous opinion, determined that the dentists' concerted refusal to cooperate with these cost containment efforts was an economically motivated conspiracy, a principal purpose of which was to reduce the threat to dentists' revenues posed by these insurer/patient efforts to control dental costs.

In reversing the Commission's decision, purportedly for lack of substantial evidence, the court of appeals misconstrued the economic relationships involved, ignored the relevant evidence adduced before the Commission, and erroneously credited the conspirators' claim that they were acting merely to further "legal, moral, and ethical" policy goals. The court's ruling distorts antitrust analysis to reflect the social and economic objectives of colluding health care providers at the expense of the procompetitive objectives embodied in the antitrust laws.

1. The court of appeals grossly misapplied the substantial evidence standard of review and this Court's precedents regarding analysis of horizontal restraints of trade in overturning the Commission's finding that the boycott was anticompetitive. The court held that there was no evidence that dentists compete with each other with respect to their policy of submitting x-rays to insurers. That simply is not so, and IFD did not even argue this position before the Commission.

The record demonstrates that cooperation with the cost containment efforts of insurance companies is an important service offered by dentists. Insurers, who together with consumers are the purchasers of dentists' services, seek access to x-rays to determine whether prescribed treatments fall within the insurers' contractual obligation to pay for the least expensive yet adequate care.

In the absence of the conspiracy led by IFD, each dentist would decide individually whether to provide x-rays to insurers. Since failure to submit x-rays could (and often did) result in insurers' inability to evalulate and pay patients' claims, both insurers and insured patients would be expected to favor cooperating dentists over those who refused to provide x-rays. As the Commission aptly stated, and as the evidence demonstrates, "individual dentists would have been subject to market forces of competition, creating incentives for them to treat patients and comply with the requests of patients' third-party insurers" (Pet. App. 85a).

2. Next the court compounded its error by holding that, even if submitting x-rays to insurers were an element of competition among dentists, the evidence before the Commission did not show that the boycott had an anticompetitive effect. This case involved a conspiracy among direct competitors to restrict an important element of the service they offer to patients—providing x-rays sought by insurers to facilitate both payment of patients' claims and cost containment efforts. The conspirators agreed jointly to withhold from buyers information that buyers deemed useful in making a purchasing decision. The conspiracy achieved widespread adherence among dentists throughout Indiana and in IFD's areas of concentration. As a result, competition among dentists with respect to providing x-rays largely was eliminated. These facts are more than sufficient to demonstrate an unreasonable restraint of trade, absent a showing that the concerted conduct itself generated offsetting procompetitive effects. Since the court of appeals did not purport to find any procompetitive effects—and the record contains no evidence that such effects exist—the decision below cannot stand.

3. Finally, the court of appeals erred by accepting IFD's contention that its boycott constituted mere collective adherence to an established "legal, moral, and ethical" policy to promote "quality dental care." In addition to ignoring well supported Commission findings that the boycott had substantial economic motivations and did not in fact serve health or safety purposes, the court's implicit acceptance of IFD's asserted noncompetitive justifications for the boycott threa as erosion of this Court's holding that ethical norms are relevant to antitrust analysis only insofar as they "serve to regulate and promote * * * competition." *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978). For that reason as well, the decision should be reversed.

ARGUMENT

THE COURT OF APPEALS MISAPPREHENDED AND GROSSLY MISAPPLIED THE STANDARD OF REVIEW IN OVERTURNING THE COMMISSION'S DETERMINATION THAT IFD'S CONDUCT CONSTITUTED AN UNREASONABLE RESTRAINT OF TRADE

It is settled that "[t]he weight to be attributed to the facts proven or stipulated [in proceedings before the Federal Trade Commission], and the inferences to be drawn from them, are for the Commission to determine, not the courts." *Corn Products Refining Co.* v. *FTC*, 324 U.S. 726, 739 (1945); see also *FTC* v. *A.E. Staley Manufacturing Co.*, 324 U.S. 746, 758 (1945); 15 U.S.C. 45(c) (upon judicial review of the Commission's orders, "findings of the Commission as to the facts, if supported by [substantial] evidence, shall be conclusive"). This deferential standard of judicial review "frees the reviewing courts of the time-consuming and difficult task of weighing the evidence, it gives proper respect to the expertise of the administrative tribunal and it helps promote the uniform application of the statute." *Consolo* v. *FMC*, 383 U.S. 607, 620 (1966) (footnote omitted).

This Court has cautioned against judicial encroachment upon the Commission's fact-finding authority, holding that the courts of appeals may not "make [their] own appraisal of the [evidence], picking and choosing for [themselves] among uncertain and conflicting inferences." *FTC* v. *Algoma Lumber Co.*, 291 U.S. 67, 73 (1934); see also *FTC* v. *Standard Education Society*, 302 U.S. 112, 117 (1937). More recently, the Court observed in a related context that reversal of a court of appeals' decision regarding an agency's factual determinations is appropriate if the

lower court " 'misapprehended or grossly misapplied' the substantial evidence test." *American Textile Manufacturers Institute* v. *Donovan, Inc.*, 452 U.S. 490, 523 (1981) (citation omitted).

The court of appeals in the present case grossly misapplied the standards governing judicial review of the Commission's decisions. Cf. *FTC* v. *Algoma Lumber Co.*, 291 U.S. at 73 ("[t]he Court of Appeals, though professing adherence to [the proper standard of review], honored it, we think, with lip service only"). Thus, the court below ignored record evidence supporting the Commission's determinations, and considered factual issues that had not been contested before the Commission. Moreover, the court of appeals endorsed the conspiracy led by respondent as the promotion of a "moral, legal, and ethical" policy, despite the Commission's express finding that respondent's actions could not be justified on that basis. In sum, the decision below reflects a manifestly undeferential and hostile approach to the Commission's findings in this case that is irreconcilable with the standard of review prescribed by Congress and consistently applied by this Court. When the proper standard is applied, it is clear that the Commission's decision is supported by substantial evidence, and that the Commission's order accordingly should be enforced.

A. The Court Of Appeals Improperly Substituted Its Judgment For That Of The Commission By Rejecting The Commission's Finding That IFD's Boycott Had An Anticompetitive Effect

The Commission found (Pet. App. 78a-96a) that the IFD boycott constituted an unreasonable restraint of trade violative of Section 1 of the Sherman Act,

15 U.S.C. 1; analyzing the boycott under the rule of reason, the Commission concluded that IFD's conduct had the effect of suppressing competition. See *Professional Engineers*, 435 U.S. at 691; *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918).[13] Before discussing the abundant record evidence supporting the Commission's determination, it is appropriate to examine the economic relationships relevant to the restraint at issue in this case.

The health care industry is characterized by the presence of third-party payors, principally insurance companies. Thus, the "buyer" of health care services in most circumstances consists of both the patient and a third-party payor. Moreover, it is often the third-party payor that bargains over the price of health care services, reacting to the cost concerns that normally drive buyers' purchasing decisions. See *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 924-926 (1st Cir. 1984), cert. denied, No. 84-1353 (Apr. 15, 1985); *Pennsylvania Dental Association* v. *Medical Services Association*, 745 F.2d 248, 256 (3d Cir. 1984), cert. denied, No. 84-1296 (Apr. 15, 1985).[14] As the Commission found (Pet. App.

[13] The "[u]nfair methods of competition" proscribed by Section 5(a)(1) of the Federal Trade Commission Act, 15 U.S.C. 45(a)(1), include restraints of trade violative of Section 1 of the Sherman Act, 15 U.S.C. 1. See *FTC* v. *Cement Institute*, 333 U.S. 683, 693 (1948). The Commission applied Sherman Act precedents in reaching its decision (Pet. App. 74a-78a).

[14] Insured patients generally will be less concerned about the cost of a particular treatment because that cost is defrayed entirely or substantially by the insurer. However, insured patients (or the employers and unions that negotiate and contract for health insurance on their behalf) necessarily are concerned about health insurance premiums (see pp. 2-4, *supra*) and the size of such premiums depends upon the insurer's ability to minimize its costs by avoiding liability for unnecessary treatment. Indeed, the premiums involved in this case were directly tied to the anticipated level of claims over the policy term (Pet. App. 147a n.48).

228a), "[t]he insurers broadly represent the economic interests of the dentists' patients."

The particular economic practice at issue here, IFD's campaign against the submission of x-rays to insurers, can be viewed in general terms as a group boycott because it is "a method of pressuring a party with whom one has a dispute by withholding or enlisting others to withhold, patronage or services from the target." *St. Paul Fire & Marine Insurance Co.* v. *Barry*, 438 U.S. 531, 541 (1978) (footnote omitted). Here, the sellers (dentists) have attempted to exert pressure upon the buyers (patients and insurers), by withholding certain services from the buyers (the submission of x-rays to insurers).

As this Court recently observed (see *Northwest Wholesale Stationers, Inc.* v. *Pacific Stationery & Printing Co.*, No. 83-1368 (June 11, 1985), slip op. 9-10), the term "group boycott" encompasses a wide variety of activities. The dentists' agreement resembles two types of restraints that previously have been found to violate the antitrust laws. First, this Court has held that the antitrust laws prohibit agreements by competitors to refuse to deal with purchasers except upon collectively specified terms. See *Paramount Famous Lasky Corp.* v. *United States*, 282 U.S. 30 (1930); cf. *NCAA* v. *Board of Regents*, No. 83-271 (June 27, 1984), slip op. 11-13. Here, the dentists collectively specified one term of their agreements with the patient/insurer buyers.

Second, the dentists' agreement denied buyers information required for cost containment purposes.

It is thus similar to the restraint on competitive bidding held unlawful in *Professional Engineers*, 435 U.S. at 692-693, because it precluded sellers from supplying buyers with information they perceived as useful in deciding whether to purchase and how much to pay, thereby obstructing the operation of competitive market forces.

As in these previous cases, no elaborate analysis is needed to show the anticompetitive effect of the dentists' agreement at issue here.[17] The restraint deprives buyers of important information in a manner that insulates the dentists from the competitive forces of the marketplace, with respect to both cooperation with insurers regarding the submission of x-rays and the larger issue of cost containment.

The court of appeals plainly erred in concluding that the evidence before the Commission did not support the finding that the dentists' conspiracy had an anticompetitive effect. The court's decision rested on two grounds. First, that dentists' willingness to submit x-rays to insurers is not an element of competition among dentists, and second, that even if such competition existed, it was not adversely affected by IFD's boycott. The court's assessment of the record with respect to both of its conclusions is fundamentally flawed.

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[17] The Commission declined to classify the conspiracy as per se unlawful, in significant part because it wanted to consider the justifications for the agreement advanced by IFD (see Part B, *infra*) and also because the type of restriction involved in this case had "not been the subject of frequent prior antitrust analysis" (Pet. App. 76a-77a).

1. *A Dentist's Willingness To Submit X-rays To Insurers Is An Element Of Competition Among Dentists*

The court of appeals' conclusion that the Commission failed to establish that IFD's boycott had an anticompetitive effect is based largely on its view that the Commission failed to prove that dentists compete with respect to submission of x-rays to insurers (see Pet. App. 37a). In reaching this conclusion, the court of appeals decided an issue that IFD never raised before the Commission. Moreover, the proposition that providing x-rays to insurers is an element of competition among dentists is supported by both common sense and substantial record evidence.

Common sense dictates that if there is something that buyers want (or could find useful), it perforce becomes an element of competition. Indeed, the Court recognized this fact in *Professional Engineers*, 435 U.S. at 695, when it stated that the legislative judgment in favor of competition that underlies the antitrust laws applies to "all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost."

The element of the bargain between patient, insurer, and dentist at issue here—the submission of x-rays to insurers—plainly is an element of competition among dentists. There is strong buyer demand for dentists to provide x-rays to insurers, and strong incentives for individual dentists to do so. Insurers consider x-ray inspection to be an efficient means of evaluating claims in order to contain costs. Patients want dentists to cooperate with insurers' requests for x-rays because a dentist's refusal could delay or even foreclose payment by the insurer, and thereby delay or prevent the patient from obtaining desired care.

See pp. 3-4, *supra*.[18] The individual dentist, an "independent competing entrepreneur[]" (*Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332, 357 (1982)), thus has a strong economic incentive to satisfy the demands of patient and insurer; failure to do so could cause the patient to take his business elsewhere.

In the proceedings before the Commission none of the parties doubted that providing claims information requested by patients' insurers is an element of competition among dentists.[19] IFD expressly acknowledged in briefs before the Commission that "[d]entists who are not members of [IFD] will naturally get favorable treatment from insurers, unions, and employees with whom they may contract" (JA. 181) and that "[p]atients desirous of x-ray submission seek out complying dentists thus promoting novel insurance oriented dental clinics" (*id.* at 186).[20] The

[18] Alternatively, if treatment has already been provided, the consumer may have to pay a greater sum out of pocket if the dentist does not assist in obtaining insurer approval of the claim.

[19] Indeed, IFD's failure to raise this issue before the Commission barred the court of appeals from overturning the Commission's order on this ground. This Court stated in *United States* v. *L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 37 (1952), that "[s]imple fairness to those who are engaged in the tasks of administration, and to litigants, requires as a general rule that courts should not topple over administrative decisions unless the administrative body not only has erred but has erred against objection made at the time appropriate under its practice."

[20] To illustrate its point, IFD cited the testimony of a dentist who had joined the boycott and lost a patient because of his refusal to submit x-rays to the patient's insurer (see J.A. 51).

State of Indiana, which intervened before the Commission on IFD's behalf (Pet. App. 127a-128a) also acknowledged that "[*a*]*ssuming* that a percentage of dentists in a particular area do not submit insurance x-rays, it is only reasonable, and foreseeable, that the remaining dentists who *do* supply x-rays will have a competitive edge when seeking insurance related business" (J.A. 172-173 (emphasis in original)).

The conspirators' documents of record (Pet. App. 289a-314a) demonstrate that a dentist's refusal to cooperate with insurers was perceived as having competitive consequences; the conspirators repeatedly observed that patients shifted to dentists who submitted x-rays pursuant to insurers' requests. For example, a dental society newsletter published early in the conspiracy complained that some Indiana dentists were ignoring the boycott and submitting x-rays "in an attempt to gain economic advantage over their peers" (*id.* at 289a). These dentists were accused of an "unethical practice [that] puts increasing pressure of a monetary nature" on their competitors (*ibid.*).[21]

In the same vein, a group of oral surgeons from Fort Wayne jointly wrote to their local IDA chapter to protest the "unethical" behavior of a competing practitioner who was gaining business from them by agreeing to submit x-rays to insurers (Pet. App. 182a n.147, 313a-314a). The surgeons noted (*id.* at 314a) that they were petitioning their dental society's "Ethics and Censorship Committee" in an effort to bring the offending competitor into line and hinted that if the competitor continued to submit x-rays to

[21] The same newsletter warned that dentists who violated the boycott might continue to do so because cooperation with insurers would be "the way to the *greatest personal financial gain*" (Pet. App. 293a (emphasis in original)).

insurers, then "we as oral surgeons may have to alter our present direction regarding submission of films" —*i.e.*, begin to compete on the same basis.

The gain or loss of patients as a result of a dentist's approach toward submission of x-rays to patients' insurers also was acknowledged in dental society documents discussing the fact that in border areas "[Indiana] dentists who do not submit radiographs are hurt by the willingness of fellow dentists in urban Louisville in Kentucky who will intentionally do this to gain a patient" (Pet. App. 307a). As a result of competition from Kentucky dentists who "will send radiographs to Aetna," one IDA member reported that "many Indiana dentists in the New Albany area had lost entire families to Kentucky dentists" (*id.* at 300a) and the Louisville area was viewed as one of the few in which the IDA/IFD boycott was weak (*id.* at 311a).

It is thus evident that the Commission did not merely "assume[] without substantial evidentiary support in the record" that "because IFD member dentists acted in concert rather than individually, competition had to exist among and between dentists in their policy of dealing with insurers" (Pet. App. 38a-39a).[22] The existence of competition among dentists with respect to their willingness to submit x-rays to insurers was recognized by all parties to the proceeding and demonstrated by weighty record evidence that plainly is such " 'as a reasonable mind might accept

[22] It is true, however, that if providing information requested by insurers were not an element of competition among dentists, there would have been no need for a conspiracy, complete with elaborate enforcement mechanisms (see pp. 7-8, *supra*), to enable individual dentists to implement their purported "legal, moral, and ethical" views in dealing with insurers.

as adequate to support a conclusion.' " *American Textile Manufacturers Institute, Inc.* v. *Donovan*, 452 U.S. at 522-523, quoting *Universal Camera Corp.* v. *NLRB*, 340 U.S. 474, 477 (1951).[23]

2. *The IFD Boycott Restrained Competition Among Dentists*

The court of appeals also concluded that even if providing x-rays was an element of competition among dentists, the Commission did not show that the dentists' conspiracy to withhold x-rays had an anticompetitive effect. In reaching this conclusion the court grossly misapplied both the substantial evidence test and this Court's precedents regarding analysis of competitors' agreements in restraint of trade.

As we have discussed (see pp. 25-26, *supra*), the type of horizontal agreement here resembles other restraints of trade this Court has found unlawful. Here, as in *Professional Engineers*, a conspiracy deprived buyers of information that the buyers deemed useful in deciding whether to purchase and how much to pay. While the conspiracy "is not price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." *Professional Engineers*, 435 U.S. at 692.

The Commission, however, did not rely merely on the nature of the agreement to support its finding

[23] Even the court of appeals recognized that dentists compete by, inter alia, cooperating with patients' insurers. In discussing IFD members' willingness to allow in-office and in-mouth examinations by insurance company dentists, the majority noted that "the IFD member dentists, did, in fact, compete among themselves and with non-IFD dentists in their billing of patients covered by group dental health care plans and *in their policy of dealing with the insurers*" (Pet. App. 42a (emphasis added)).

that the agreement had an anticompetitive effect. The Commission found that IDA and IFD had the market power to make their boycott effective. IDA was composed of 85% of all dentists licensed in Indiana; it enlisted most of its members in the boycott (Pet. App. 151a-152a, 172a-175a). In continuing IDA's statewide conspiracy in selected localities, IFD achieved participation by nearly 95% of practicing dentists in Madison County and all but a few dentists in the area covered by its Lafayette Chapter (p. 9, *supra*; Pet. App. 39a-40a).[24] Where the boycott held sway, dentists refused to submit x-rays to insurers or did so only covertly because they feared reprisal. Thus to a very considerable degree, competition among dentists was eliminated with respect to their submission of x-rays to insurers (Pet. App. 83a-86a).

The Commission also chronicled the impact of this restraint of dentists' competition. In various localities the flow of x-rays to insurers was reduced to a trickle and patients were inconvenienced by late payment or non-payment of claims and the inability to find den-

[24] Because the boycott, which IFD was formed to continue, included almost the entire state of Indiana during IDA's stewardship and persisted in the areas in which IFD was organized, the Commission properly concluded (Pet. App. 85a n.12), that no more elaborate analysis of the market was required. See *NCAA* v. *Board of Regents*, slip op. 23-24 & n.42. While IFD challenged the Commission's findings regarding membership percentages (which were derived from IFD's own documents), these findings were not rejected by the court of appeals. Moreover, even IFD's preferred figures (J.A. 187-190) would place its membership at 66%-69% of dentists practing in Madison County and 50%-56% of those in the Lafayette area. Compare *Paramount Famous Lasky Corp.* v. *United States*, 282 U.S. at 44.

tists willing to cooperate with insurers. Insurers, as surrogates for consumers, were thwarted in their efforts to use x-rays as a means of containing the costs of dental care (Pet. App. 83a-86a; see also pp. 9-12, *supra*). This evidence was more than sufficient to support the Commission's condemnation of this restraint of trade, absent some showing (of which the court found none, see Part B, *infra*) of a countervailing benefit to competition. *NCAA* v. *Board of Regents*, slip op. 26; *Professional Engineers*, 435 U.S. at 692; cf. *Paramount Famous Lasky Corp.* v. *United States*, *supra*.[25]

In rejecting the Commission's carefully articulated and substantiated finding of anticompetitve effect, the court of appeals reweighed the evidence in direct violation of the standards governing judicial review of the Commission's decisions. See *FTC* v. *Algoma Lumber Co.*, 291 U.S. at 73; see also *American Textile Manufacturers Institute, Inc.* v. *Donovan*, 452 U.S. at 523; *Steadman* v. *SEC*, 450 U.S. 91, 99 (1981). For example, the court found (Pet. App. 28a-29a, 42a-43a) that the boycott was not "complete" because insurers could review x-rays by visiting dentists' offices. The court rejected the Commission's finding that in-office visits by insurers were "prohibitively expensive" (Pet. App. 88a) on the ground that this finding was "tempered" by evidence that "smaller insurers had generally gone along with the Indiana

[25] Judge Fairchild agreed that "[t]here is little question that the Indiana Dental Association organized boycott of insurers' requests for x-rays had a significant economic impact on the functioning of group dental plans within Indiana" (Pet. App. 46a).

dentists' demands"[26] and that group dental health care insurers visited dental offices to examine and review all diagnostic and clinical aids (*id.* at 42a-43a).[27]

Even if smaller insurers acquiesced in the boycott by abandoning x-ray review and larger insurers in some instances agreed reluctantly to conduct the in-office visits demanded by the dentists, these facts demonstrate only that the boycott succeeded in its purpose of thwarting insurers' cost containment efforts. They do not show that the boycott lacked an anticompetitive effect. Similarly, the fact that some dentists continued to cooperate with insurers establishes only that the boycott was less than 100% successful, not that it failed to restrain trade significantly. An agreement need not eliminate all competition in order to amount to an unreasonable restraint of trade. See *Paramount Famous Lasky Corp.* v. *United States*, 282 U.S. at 44.

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[26] In making this finding, the court of appeals quoted a statement by the ALJ (Pet. App. 177a) that was based upon a single IDA document (CX 39-B) written in 1971, a time when there was very little group dental insurance business in Indiana. Nothing in the document supports the proposition for which the court (but not the Commission or ALJ) used it—that smaller insurers found it economically feasible to conduct in-office visits to review each claim. In fact, "go-[ing] along" with IDA could as easily mean not making any serious attempt to scrutinize claims (and contain costs) as engaging in cumbersome in-office visits to review each claim.

[27] This finding was an apparent reference to the experiences of Aetna and Connecticut General, which, contrary to the court's assumption, demonstrated that in-office claims review was so expensive and cumbersome that even large insurers could afford to use such a procedure for only a very limited time in a very limited area. See pp. 10-12, *supra*.

The court also concluded that any costs imposed by insurer acquiescence in the boycott affected only "the insurers in their review of dental claims" (Pet. App. 43a). Even if this were so, it would hardly disprove the Commission's finding of an adverse effect on competition. But as the Commission recognized, costs to insurers are ultimately borne by consumers, and thus the "final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs" (*id.* at 86a). Cooperation with insurer cost containment efforts was desired by the purchasers of dental insurance as well as by the insurers. This element of consumer demand, which competition among dentists could otherwise be expected to meet, was left unsatisfied as a result of the dentists' conspiracy.

In addition to this improper reweighing of the evidence, the court also imposed on the Commission the burden of demonstrating that the boycotted cost containment programs were effective in reducing premiums (Pet. App. 41a). Leaving aside the practical difficulties of making such a showing (*id.* at 88a),[28] the court's novel test amounts to a requirement that the consumer choice affected by a restraint of trade (here, the submission of x-rays to insurers) be shown to be reasonable or somehow objectively "good" for society before a conspiracy to eliminate that con-

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[28] Certainly nothing in the record casts doubt on the conclusion that x-ray review helps to limit health care costs by allowing insurers to reject unnecessary treatments without the prohibitively costly expense of an in-office visit to review every proposed treatment. While insurance company representatives testified that, as a practical matter, they were unable to quantify the effects of their cost containment programs, they believed them to be effective. See, *e.g.*, J.A. 2-3, 20-25, 29-31; cf. J.A. 39.

sumer choice may be condemned under the antitrust laws. However, all that is necessary under the antitrust laws is a showing that the element of competition foreclosed is desired by purchasers of dental services patients and insurers. A suppliers' cartel may not impose its contrary preference, even if it believes that consumers' preferences were misguided. See *NCAA* v. *Board of Regents*, slip op. 23; *Professional Engineers*, 435 U.S. at 695; *Fashion Originators' Guild, Inc.* v. *FTC*, 312 U.S. 457 (1941); Pet. App. 88a (FTC decision).

B. The Court Of Appeals Erred By Crediting IFD's Assertion Of Legal, Moral, And Ethical Justifications For The Boycott

As we have shown, the anticompetitive nature of IFD's conduct is clear from the record in this case. The only issue remaining under the rule of reason, and the principal focus of IFD's defense before the Commission (Pet. App. 73a), is whether the conspiracy had procompetitive benefits that somehow outweighed the injury to competition caused by the challenged restraint. See *NCAA* v. *Board of Regents*, slip op. 23; *Professional Engineers*, 435 U.S. at 693.

IFD argued that the boycott did not violate the antitrust laws because it was necessary to promote health and safety and ensure quality dental care. The Commission rejected these contentions, finding no evidence that any consumer received substandard dental care or suffered any injury as a result of insurer examination of x-rays (Pet. App. 91a-92a, 240a-241a). The Commission also found no state law requirement barring health care providers, such as dentists, from furnishing third-party payors with patient information (*id.* at 100a-101a).

The court of appeals, on the other hand, based its analysis on the premise that the boycott furthered "legal, moral, and ethical" goals, and that the position adopted by the conspirators reflected "established, accepted, and approved standards of quality dental care" (Pet. App. 21a-24a). Indeed, the majority repeatedly invoked these phrases (more than 20 times), as though they were established fact, ignoring the Commission's express finding to the contrary (*id.* at 91a-96a).[29] Although the court did not state in so many words that its holding rested upon these asserted noncompetitive justifications for the IFD boycott, it did acknowledge that its "analysis stems from the fact that the conduct of the IFD member dentists is not designed to drive out competitors but to promote a legal, moral, and ethical policy of quality and proper dental care" (*id.* at 33a n.15).

Implicit in the court's opinion is its apparent view that the mere assertion of justifications unrelated to the competitive effect of a challenged restraint should weigh heavily in cases concerning conspiracies by professionals to subvert competition. However, this Court has "refused to tolerate manifestly anticompetitive conduct simply because the health care industry is involved." *Jefferson Parish Hospital District No. 2* v. *Hyde*, No. 82-1031 (Mar. 27, 1984), slip op. 22

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[29] The court characterized the IFD boycott as nothing more than the "dentists' concerted effort to ensure quality dental care" (Pet. App. 29a), and described the issue in the case variously as whether IFD engaged in a group boycott by collectively "adhering to a policy that complies with the established, accepted, and approved standards of quality dental care" (*id.* at 24a) and whether substantial evidence supported the Commission's finding that "the dentists' adherence to a legal, moral, and ethical policy of quality and proper dental care * * * had an anticompetitive effect" (*id.* at 37a).

n.42. The Court's decisions make clear that lower courts should carefully scrutinize anticompetitive conduct of private associations of professionals and other entrepreneurs, even when purportedly carried out in the name of "ethics," "morals," "public health or safety," or "law." *See Professional Engineers*, 435 U.S. at 679 (ethical prohibition on competitive bidding purportedly aimed at preventing shoddy and unsafe work); *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975) (pricefixing under an ethical guise); *American Medical Association* v. *United States*, 130 F.2d 233, 249 (D.C. Cir. 1942), aff'd, 317 U.S. 519 (1943) (boycott of group health plan on purported ethical and health grounds); *Fashion Originators' Guild, Inc.* v. *FTC*, 312 U.S. at 467-468 (boycott against style copiers allegedly violating state tort law).[30] Thus, as the court of appeals itself acknowledged, "rule of reason analysis 'does not open the field of antitrust inquiry to any argument in favor of a

[30] The cases establish that competitors cannot invoke "quality" as a defense when they restrict consumer choice by imposing on the market their own view of the appropriate level of quality. The antitrust laws recognize, however, the procompetitive potential of attempts to improve quality by making available either new or improved products or services, or more reliable information about the quality of existing products or services. Cf. *Broadcast Music, Inc.* v. *CBS*, 441 U.S. 1, 18-23 (1979). For example, in settings involving hospital privileges or specialty certification standards of private professional organizations, reasonable standards that foster quality or enhance efficiency and that are not more restrictive than necessary to accomplish their legitimate objectives will pass muster under traditional antitrust analysis because they enhance competitive market forces. See, *e.g.*, *Professional Engineers*, 435 U.S. at 696; *Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd, 688 F.2d 821 (3d Cir.) (Table), cert. denied, 459 U.S. 971 (1982).

challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions' " (Pet. App. 34a, quoting *Professional Engineers*, 435 U.S. at 688)[31]

In applying the *Professional Engineers* standard to IFD's asserted justifications, the Commission recognized that "some situations will present difficult factual questions" (Pet. App. 94a). This case, however, did not. As we demonstrate below, IFD's professed "legal, moral, and ethical" justifications for its conduct are of no substance. IFD, which bore the burden of establishing any justification for its conspiracy (cf. *NCAA* v. *Board of Regents*, slip op. 26), failed even to make the threshold showing that would enable a factfinder (let alone a reviewing court) to conclude that the asserted "legal, moral, and ethical" purposes of its boycott bore in any way upon the procompetitive goals of Section 5 of the Federal Trade Commission Act.

1. *IFD Did Not Show That Moral Or Ethical Considerations Prohibit Insurer Use Of X-rays For Claims Review*

The court of appeals erroneously assumed that insurers who requested x-rays were violating established standards of care by "formulat[ing] a course of dental treatment * * * based solely upon an insurance claim form and copies of a patient's dental x-rays " (Pet. App. 29a; see also *id.* at 3a, 22a-23a,

[31] Indeed, respondent IFD has disavowed any attempt to defend its boycott on grounds of affirmative justification, contending that the court of appeals' decision properly "delineates that professional motives do not excuse anticompetitive conduct" (Br. in Opp. 11).

28a, 29a, 32a, 39a, 44a). This led the court to conclude that "*insurers* cannot be permitted to forsake standards of quality and proper dental care in an attempt to lower their dental costs" (*id.* at 44a (emphasis added)). In fact, of course, insurers merely determine the extent of their liability under the insurance contract; the patient alone, after considering the dentist's advice, selects the course of treatment. At no stage of these proceedings has IFD submitted any evidence that x-ray inspection *for claims review purposes* threatens any medically undesirable results.[32]

As noted above (pp. 3-4, *supra*), insurers use x-rays to separate the majority of patently justified claims from claims warranting further scrutiny. The lay examiners who conduct this initial screening process are authorized only to grant claims; they cannot deny them. In cases in which initial review of the claim form and x-ray suggests the need for further scrutiny, the claim is referred to a licensed dentist employed by the insurer. Only this licensed dentist may recommend to the insurer that a particular claim be denied, and he generally does so only after consulting the treating dentist. See pp. 3-4, *supra*.

In light of these facts, IFD failed to demonstrate, and, indeed, did not even argue before the Commission "that any consumers have in fact been harmed by alternative benefits determinations, or that actual determinations have been medically erroneous" (Pet. App. 91a). Likewise, the Commission found that IFD did not cite even "a single instance * * * where any dentist agreed to provide less-than-adequate treat-

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[32] For this reason, the court's discussion of why x-rays alone are insufficient to provide complete information for "diagnosis" or "treatment" (Pet. App. 22a-23a) is inapposite.

ment because of the fear of an erroneous insurance determination" (*id.* at 91a-92a). Thus, the court's conclusion that the boycott was necessary to promote quality dental care is completely without factual support.[33]

Moreover, the court of appeals' benign view of the IFD boycott is contradicted by substantial evidence cited by the Commission showing that Indiana dentists were fighting what IFD's first president called "an economic war" in which "[t]he name of the game is money" (J.A. 104). The dentists viewed the cost containment programs as an effort "to reduce the cost of the dental health dollar at the expense of the dentist" (*ibid.*) and their boycott was designed to avoid this result. IFD, in particular, was formed expressly to promote its members' economic interests and styled as a "labor union" in the misguided belief that this would immunize it from the antitrust consequences that would otherwise attach to its conspiratorial conduct (pp. 6-7, *supra*). Its credo, incorporated into its charter, recited that "only in and through a united effort can we be assured of receiving full and just compensation and due appreciation for our services" (Pet. App. 211a). The express economic purposes of the boycott belie any argument that the boycott can be justified on ethical grounds.

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[33] IFD's quality of care claim is not helped by the court's sua sponte invocation of the American Dental Association's (ADA) policies on dental care programs (Pet. App. 22a-23a, 44a). Nothing in the record indicates that dentists' provision of x-rays as requested by Indiana insurers, or the use insurers made of x-rays in the claims review process, was inconsistent with ADA guidelines (cf. Pet. App. 142a n.34).

2. *IFD Did Not Establish That Indiana Law Prohibits Use Of X-rays By Insurers*

The court of appeals' apparent belief that IFD had a colorable "legal" justification for its boycott (see Pet. App. 16a) is as unfounded as its supposition that a cognizable moral or ethical justification existed. The Commission found no Indiana law prohibiting dentists from submitting x-rays to insurers, or prohibiting insurers from using x-rays to assess insurance claims. And IFD never has argued that Indiana law authorizes ad hoc boycotts to enforce the conspirators' views of legal requirements.

The linchpin of IFD's "legal" justification for the boycott is its contention that insurers' use of lay personnel to screen x-rays constitutes the unauthorized practice of dentistry and that dentists who submit x-rays violate Indiana law as aiders and abetters (Pet. App. 243a). Both the Commission and the ALJ found, however, that Indiana law did not clearly prohibit lay personnel from screening x-rays for the purpose of referring questionable claims to a licensed dentist (*id.* at 100a-101a, 243a-260a) and the court of appeals did not challenge this conclusion.[34]

Moreover, as the Commission also found, even if there were some colorable basis for the belief that an insurer's use of lay personnel to review x-rays violated Indiana law, that fact could not excuse IFD's boycott. Nothing in Indiana law sanctions an ad hoc coercive boycott as a means of enforcing professional code requirements, and this Court has long frowned

[34] The record reflects "no evidence * * * that the Attorney General of Indiana or anyone else has ever charged * * * any layman of practicing dentistry without a license on the ground that such person screened X-rays for a dental health care insurer" (Pet. App. 252a; see also *id.* at 259a).

on the use of collective boycotts as a means of imposing upon the marketplace economic competitors' own vision of morality or law. *Fashion Originators' Guild, Inc.* v. *FTC*, *supra*.[35]

[35] The Commission's findings with respect to the meaning of Indiana law (Pet. App. 97a-104a) also dispose of the single issue not addressed by the court of appeals (*id.* at 45a n.18) —whether IFD's conduct is exempt from antitrust liability under the state action doctrine. Anticompetitive conduct by private parties is entitled to immunity under this doctrine only if the conduct is (1) undertaken pursuant to a clearly articulated, affirmatively expressed policy of the state, acting in its sovereign capacity, to displace competition and (2) actively supervised by the state. *Southern Motor Carriers Rate Conference, Inc.* v. *United States*, No. 82-1922 (Mar. 27, 1985), slip op. 8; *California Retail Liquor Dealers Association* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 105-106 (1980). Plainly, IFD can point to no clearly articulated, affirmatively expressed policy of the State of Indiana to displace competition among dentists with respect to their submission of x-rays to insurers who request them. Similarly, there was no state supervision of IFD's conspiratorial conduct. Accordingly, this Court need not remand this case to the court of appeals for resolution of the state action issue.

CONCLUSION

The judgment of the court of appeals should be reversed and the case remanded with instructions that the court affirm and enforce the order of the Commission.

Respectfully submitted.

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RESPONDENT'S

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

FEDERAL TRADE COMMISSION,
Petitioner

v.

INDIANA FEDERATION OF DENTISTS,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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QUESTIONS PRESENTED

1. In applying the rule of reason to a non-price restraint promulgated by a professional organization, must the Federal Trade Commission consider quality of care justifications proffered in defense of the alleged restraint?

2. In establishing that such a restraint is unlawful, must the Commission introduce substantial evidence showing that the restraint had an adverse impact on actual competition in defined product and geographic markets?

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

No. 84-1809

FEDERAL TRADE COMMISSION,
Petitioner

v.

INDIANA FEDERATION OF DENTISTS,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF OF RESPONDENT

STATEMENT OF THE CASE

A. Introduction

This case concerns the legality of a rule promulgated by a small association of dental care professionals that discouraged its members, certain Indiana Dentists, from submitting x-rays to a few major insurance companies.

Prior to issuance of the complaint by the Federal Trade Commission (Commission), some insurance companies sought to require dentists whose patients were insured by them to submit x-rays for examination by lay personnel

employed by the insurance companies. The companies justified these requests by claiming that analysis of x-rays would assist them in deciding whether prescribed or completed treatment of their insureds was appropriate and necessary. Even though the companies claimed these requirements would help save costs and reduce insurance premiums, there is no evidence that the x-ray requirement in fact contained (or lessened) costs.

The small group of Indiana dentists that is the target of this federal enforcement action was organized in 1976 under the name Indiana Federation of Dentists ("IFD"). The fundamental purpose of IFD was to preserve and maintain high standards of dental care.

B. Operation of the Plans

The controversy in this case arises from the implementation and operation of two provisions that insurance companies include in their group dental plans: "predetermination of claims" and "least expensive adequate treatment."[1] Under the "predetermination of claims" provision the dentist and patient may, in their discretion, submit a proposed treatment to the insurer for a preestimate of payable benefits. The "least expensive adequate treatment" provision allows the insurer to make a determination of the least expensive dental treatment that will supposedly provide good dental care (Pet. App. 61a, n.4). The insurer, based upon its independent determination of what the least expensive but adequate dental treatment should be, will only reimburse the patient (insured) for the cost of the alternate treatment.

[1] Group dental plans originated in Indiana in the early 1970's. These plans were included in collective bargaining agreements for the benefit of union employees (Pet. App. 2a). While the record refers to several group dental plans operating in Indiana (e.g. General Motors, International Harvester, J.I. Case), the record fails to specify the geographical distribution and locations of the insured employees and their respective dentists.

(Pet. App. 2a) In recent years, "least expensive adequate treatment" has been euphemistically termed "alternate benefits." This case focuses on the use and abuse of "least expensive adequate treatment" provisions by major insurance companies.

To enforce these provisions, group dental insurers directed treating dentists to submit the patient's dental radiographs (x-rays) along with the patient's insurance claim form. (Pet. App. 3a) The x-rays and claim form would then be reviewed by lay personnel employed by the insurance company.[2]

Supposedly, if a lay examiner questioned the propriety of a prescribed dental procedure, the matter would be referred to a licensed dental consultant employed by the insurance company. (J.A. 3a) Based only upon an analysis of the claim form and x-rays, and without the use of any other diagnostic aids, much less an oral examination, the insurer's dental consultant would determine the *least expensive* type of dental treatment that would, from the insurer's viewpoint, provide good dental care. (J.A. 21).[3]

After the dental consultant decided what alternate treatment would be adequate, he offered his opinion to the lay claims processor who would then make a benefit determination. (J.A. 21) This determination would be made solely on the basis of the patient x-ray and the dental claim form. (Pet. App. 3a) Gerhard R. Schade, Jr., Aetna claims manager, bluntly asserted that "Our consultants can verify the diagnosis by reviewing the x-ray. . ." (J.A. 25) Similarly, Jacob Hurwitz, Senior Health Care consultant for the United Auto Workers stated:

[2] Many of the lay examiners reviewing dental diagnostic materials had only high school educations and none were dentists. (J.A. 151). Lay examiners were allowed to read and interpret x-rays to establish numerous dental conditions (J.A. 157).

[3] The dental consultant would call the attending dentist in certain circumstances. (J.A. 21)

> Well, the preoperative x-rays were a tool for the benefit of the dental consultant, the carrier's dental consultant, to *evaluate* the proposed course of treatment by the attending dentist and *he would rely on them* for making a determination of the *adequacy* and *appropriateness* of the course of treatment proposed by the dentist. (J.A. 37-38) (emphasis supplied)

The ultimate result is that insurance companies, based solely upon an examination of an x-ray and a claim form, would agree to pay the patient for only the cost of a less expensive dental treatment than that prescribed by the treating dentist. (Pet. App. 140a, n.26) Thus, the patient was left to decide on his own whether to proceed with the dentist's prescribed treatment and make up the difference in cost (J.A. 148), or to accede to the insurer's cursory determination of what would be a "less expensive but adequate" treatment. (Pet. Br. 40) The dilemma posed to the patient and the dentist-patient relationship is evident. Judge Cale J. Holder, in granting intervention to the State of Indiana, succinctly defined this dilemma:

> [T]he power of the purse of the payors (insurers) acting through unlicensed, incompetent personnel could be the ultimate deciding factor in the diagnosis of an Indiana citizen's need for dental care. (J.A. 159)

C. Indiana Law on Dental Diagnosis

On March 6, 1974, the president of the Indiana State Board of Dental Examiners requested an opinion from the Attorney General of the State of Indiana regarding the legality of using lay clerks to review proposed courses of dental treatment. (R. 442).[4] On March 14, 1974, the Deputy Attorney General responded that:

> No clerk, who would be a layman, could possess the knowledge required to make such a diagnosis from radiographs. Neither would such a clerk have the knowledge to determine whether a proposed treatment would be proper, so that it would fall within authorized bounds.
>
> It is my opinion that only a dentist should review radiographs and proposed treatments for third party insurance companies and the use of clerks to make such reviews would be improper and should be proscribed. (R. 441)

The conclusion of the Deputy Attorney General was based on the interpretation of an Indiana statute enacted in 1913. (R. 432)

On October 9, 1974, the Indiana State Board of Dental Examiners sent Aetna a copy of the Deputy Attorney General's opinion, and advised Aetna by letter:

> The Indiana State Board of Dental Examiners are (sic) taking this position in implementing the third party dental plans. (R. 449-450)

Thereafter, the Dental Examiners promulgated an official policy based upon the Attorney General's Opinion and stated:

> [O]nly a dentist should review radiographs and proposed treatments for third party insurance companies and the use of clerks to make such reviews would be improper and should be proscribed. (R. 433-434).[5]

It was clear that by at least 1974, the Indiana State Board of Dental Examiners (the regulatory body for Indiana dentists) proscribed the lay reading and interpretation of dental x-rays by lay personnel at insurance companies.

On January 19, 1979, the Indiana State Board of Dental Examiners promulgated a letter to all Indiana dentists specifically warning that:

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[4] Seventh Circuit Deferred Appendix Citation.

[5] This promulgation was distributed to all Indiana dental schools. (R. 677)

> Dentists who knowingly submit radiographs, or other diagnostic data, to third persons, including insurance companies, that allow persons other than licensed dentists to review such data, are aiding or abetting in the unlawful practice of dentistry. These dentists are subject to criminal penalties . . . and to *revocation or suspension of their license.* (J.A. 144) (Emphasis supplied)

Similarly, the Commissioner of the Department of Insurance promulgated Bulletin #37 regarding the reading of dental x-rays. The Commissioner warned all insurance companies engaged in underwriting group dental plans that the practice of allowing personnel not licensed as dentists to evaluate dental x-rays is a violation of the insurance laws of Indiana governing unfair trade practices and the Indiana dental licensing law. Bulletin #37 continued:

> Notwithstanding that companies have been so advised, allegations are being made that certain insurance companies are currently utilizing personnel not licensed as dentists to evaluate dental x-rays. (J.A. 154)

The foregoing underscores what was evident to dentists and to the State of Indiana: insurance companies were engaging in improper diagnosis and treatment planning, and were utilizing lay personnel to read and interpret diagnostic aids in violation of Indiana dental law. Despite the efforts of the Indiana Dental Association and the Indiana Board of Dental Examiners to stop the insurers' illegal and unethical actions, the practices of the dental insurers continued.[6]

[6] IDA is a constituent society of the American Dental Association. Most dentists in Indiana belong to the IDA. Its members automatically belonged to fourteen affiliated local component dental societies. (Pet. App. 151a). The IDA was in existence during the advent of dental insurance plans, and eventually established a council on Dental Care Programs to study their implementation. (R. 702-05)

D. Formation of IFD

In 1976, a movement began among a small number of Indiana dentists to form a dental organization, separate and apart from the traditional dentists' association in Indiana, the Indiana Dental Association (IDA). Accordingly, IFD, Respondent herein, was formed. The first president of the IFD, Dr. David B. McClure, delineated the purpose for forming IFD:

> . . . unionizing is the only way dentists can meet the challenge of providing *quality dental care* for their patients under terms of dental health insurance programs. . . . Unionizing will enable dentists to be heard in negotiating with insurance companies on the *quality of care* and conditions of treatment. (J.A. 106) (Emphasis supplied)

The IFD is affiliated with the American Federation of Physicians and Dentists. (R. 271)

IFD's membership is located in and around the three localities of its chapters: Madison County, Daleville, and Middleton (Chapter 1) (R. 243-244); Tippecanoe, Clinton, White and Carroll Counties (Chapter 2) (R. 249); and Allen County (Chapter 3) (R. 255). As of 1979 IFD had approximately eighty-four (84) present members and eight (8) former members. (Pet. App. 3a) The IFD's constitution and by-laws provided that:

> The objectives of this Federation shall include but not be limited to the following:
>
> a. To represent dentists in all socio-economic matters, negotiations and grievances with employers, third, and fourth parties, or any group that is involved in the financing or delivery of dental care. *The ultimate purpose being to promote better patient care and to prevent abuses and correct inequities in the delivery of dental care to the public.* (Pet. App. 8a) (Emphasis supplied)

In April 1977, the IFD's member dentists adopted a work rule setting forth IFD's policy that proper dental

diagnosis and treatment planning necessitates a review of all diagnostic and clinical aids and not a cursory review of the patient's x-rays and insurance claim form. The IFD work rule stated in its entirety that:

> Proper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids, with a history and with all clinical findings. *No one facet of this process is now, or ever has been recognized by the profession as a substitute for the complete process. To represent otherwise would subject the patient to substandard care.*
>
> The patient's dentist, therefore, has a *moral* and *legal* responsibility to not allow a determination of his patient's condition to be made for any purpose, without the benefit of a complete examination which takes into account all of the elements described. (Pet. App. 9a) (Emphasis supplied)

Further, IFD prepared for its members a form letter reiterating the principles delineated in the work rule and offering to furnish all records and arrange for an oral examination of the patient so that a proper diagnosis could be effected. (Pet. App. 9a, 10a) Professor William Shafer, Chairman of the Department of Oral Pathology at Indiana University, endorsed the IFD work rule "one hundred percent." (J.A. 53) In fact, the record shows that the IFD work rule was grounded in sound medical policy.

E. Medical Basis for the IFD Work Rule

The record is rich with objective medical evidence demonstrating that the manner in which insurers diagnosed dental conditions and prescribed alternate treatments posed a serious danger of misdiagnosis or mistreatment. Indeed, as the ALJ concluded:

> . . . the experts—on all sides—seem to agree that an x-ray or other diagnostic aid alone is *not enough* for an accurate diagnosis. (Pet. App. 238a) (Emphasis supplied)

The ALJ delineated numerous conditions that x-rays will *not* reveal. (Pet. App. 236a-239a) Dr. Ernest Mishler, dental consultant for Connecticut General Insurance Company, admitted that he *could not* rely on x-rays alone to make a proper dental diagnosis. (J.A. 19) Dr. William Shafer, Professor and Chairman of the Department of Oral Pathology at Indiana University, stated that it was wholly improper to allow a treatment plan to be affected by judgments made by persons who had not had the benefit of an oral examination. Similarly, Dr. Shafer believed that a dentist's submission of a single diagnostic aid to a third party for the purpose of diagnosis would compromise the moral and legal responsibilities for the best patient care. (J.A. 53) Dr. Myron J. Kasle, Professor and Chairman of the Department of Radiology at Indiana University, stated that a proper diagnosis *cannot* be effected without the use of all diagnostic aids. An x-ray alone cannot provide the basis for a proper diagnosis. (J.A. 56) Dr. Kasle stated such a practice "is tantamount to malpractice." (J.A. 56-57)

Aetna's own dental contract provided for a determination of "the *total* oral condition of the patient's mouth." (J.A. 22) Aetna's own claim guide stated that "oral exams by outside dentists are the best method of determining what work has been performed." (J.A. 126) Nevertheless, the evidence demonstrates that neither Aetna nor any other relevant dental insurer ever availed themselves of the IFD dentists' continuing offer to examine the patient and *all* diagnostic aids so that the total oral condition of the patient could be determined.[7] (J.A. 5)

F. Effect of X-Ray Review on Dental Costs

Although the record abounds in evidence that determination of the "least expensive adequate treatment" based on x-rays alone was medically risky, there is no

[7] Aetna did conduct some patient examinations on a one-shot temporary basis (Pet. Br. 10)

evidence that these provisions reduced dental care costs or had any other positive economic effects. At trial, IFD pressed the Commission and its expert to produce evidence that cost-containment provisions using x-rays actually reduced or contained dental costs. The Commission refused, bluntly stating that proof of cost-containment was not important:

> Your Honor, if I might add, I want to mention also that the theory of our case, as we stated before, is not that we must show that in fact these provisions do contain costs. I mean that isn't important with respect to the allegations in the complaint. (J.A. 41)

The ALJ expressed his disappointment with the failure of the Commission to present evidence of cost-containment:

> I understand your theory, but it seems to me like this is very valuable evidence . . . I am just a little puzzled that you haven't put them in . . . I understand that; but, nevertheless, there has been a lot of evidence about this cost-containment and the mechanics of predetermination and alternate benefits and so forth. And again, it looks to me like this is a goldmine of information which is just puzzling me that you didn't put in. (J.A. 40, 41)

Although there is no evidence (and no finding) that review of x-rays by the insurer would reduce costs, there is evidence that compliance with dental insurance claim submission requirements (including the x-ray requirement) created additional costs to the treating dentist. Dr. Ralph D. Rohn estimated that compliance with insurance company mandates would cost an additional thirty or forty dollars a week. (J.A. 44) Dr. James G. Pierce stated that when the General Motors-Connecticut General contract became effective he was forced to hire additional help for the purpose of filling out insurance forms. (J.A. 51) Dr. Frank Miele, dental consultant for Metropolitan Insurance Company, tacitly admitted that predetermination itself is a costly procedure. (J.A. 32)

The dentists' refusal to submit x-rays resulted in some dental insurer administrative problems. However, these problems were caused primarily by unilateral decisions of the insurers themselves. The insurers, refusing to avail themselves of the use of total diagnostic aids, simply refused to pay certain claims absent submission of dental x-rays.

It is evident from the record that IFD dentists complied with insurers' demands in virtually all respects except for the automatic submission of the patient's x-ray. IFD members continually offered qualified dental consultants the opportunity to review x-rays along with all other diagnostic aids in the treating dentist's office. (Pet. App. 29a) Occasionally, the insurers took advantage of this offer and claims were then promptly processed. (Pet. App. 7a) Further, it is clear that IFD's dentists provided claim forms to the insurers, as well as complete dental charting, narrative reports, and open dialogue regarding diagnosis via telephone conversations. (E.g. J.A. 147-179)

G. Proceedings Below

1. *The Complaint*

In October 1978, the Commission issued a complaint against IFD charging it with a violation of Subsection 5 of the Federal Trade Commission Act, 15 U.S.C. § 45(A)(1). (Pet. App. 11a) The complaint alleged that IFD and its members had engaged in various acts, practices and methods of competition to eliminate, prevent, or hinder competition among dentists with respect to cooperation by dentists with dental health care benefit programs containing alleged cost-containment provisions. (Pet. App. 12a) The complaint further alleged that the practices of IFD had numerous anticompetitive effects, including price fixing. On July 19, 1979, prior to trial, Judge Cale Holder of the Federal District Court for the

Southern District of Indiana granted intervention to the State of Indiana. (J.A. 158-159)

2. *The Initial Decision of the ALJ*

On March 25, 1980, the ALJ issued his Initial Decision. The ALJ determined that the actions of IFD constituted a classic *per se* violation of the kind found in *Klors, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1958). (Pet. App. 226a) The determination that a *per se* violation had occurred was ostensibly based on the ALJ's following unsupported conclusion:

> Here there is technically neither a competitor nor a buyer/seller relationship between boycotters and boycottees but there are similar economic relationships susceptible to abuse. The insurers broadly represent the economic interest of the dentists' patients and to that end need access to the patients' x-rays for cost-containment purposes. Group action to shut off insurers' access to the x-rays is precisely the kind of organized economic squeeze play against which the boycott rule is aimed. [No citation] (Pet. App. 228a)

Alternatively, the ALJ decided that the involvement of medical services might necessitate a more extensive economic investigation utilizing the rule of reason analysis in supplementation of the *per se* finding. (Pet. App. 228a, 229a) The ALJ stated:

> Assuming, merely for argument, that the rule of reason is applicable to the facts of this case, the central question here is not whether there are any procompetitive factors to be weighed against the *anticompetitive factors already established* . . . the question is rather whether a noncompetitive factor (i.e. one which affects competitive conditions neither beneficially nor adversely) may be weighed in the balance. (Pet. App. 229a, 230a)

The supposed "anticompetitive factors already established" referred to by the ALJ were never delineated or identified in the Initial Decision. The Commission did not even try to establish the effect of IFD's practices on competition in any defined product and geographic markets.

With respect to "noncompetitive factors," the ALJ found an extensive body of medical opinion holding that x-rays alone were insufficient for diagnosis or treatment (Pet. App. 235a-239a). However, the ALJ found the record deficient as to "what supplementation of x-rays for diagnosis is the usual practice of the dental health care insurers serving Indiana." (Pet. App. 241a). Holding the IFD responsible for this deficiency, the ALJ concluded that "we have no health/safety factor to weigh in the balance. . . ." *Id.* The ALJ summed up his abbreviated "rule of reason" analysis as follows:

> Even if such a concerted refusal were not an unreasonable restraint of trade *per se*, there is no proof in this record of any procompetitive effect and no sufficient proof of any beneficial or effect on health/safety to outweigh the *plainly anticompetitive* and anticonsumer effects of the IDA/IFD group boycott of dental health care insurers. (Pet. App. 276a)

3. *The Commission's Decision*

On appeal from the Initial Decision IFD urged that the *per se* analysis be abandoned in favor of a rule of reason analysis. (J.A. 178) The IFD stated that:

> Indeed, the instant case involved unique and novel relationships which must be analyzed in terms of their actual effect on competition and trade. The effect of Respondent's conduct must be assessed in this case. (J.A. 177)

On February 17, 1983, some two years and five months after oral argument, the Commission filed its final decision and order. (R. 162-225) The Commission vacated the *per se* determination by the ALJ and employed a rule of reason analysis. (Pet. App. 76a) In reviewing the Commission's decision, it is important to recognize

that the Commission found IFD's practices to be unlawful despite the following:

1. The Commission specifically declined to decide whether the challenged practices of IFD were unfair. In refusing to do so, the Commission noted that unfairness concerns the practice's impact on consumers, principally individuals purchasing a product or service for their own consumption or investment. Thus, the Commission never found that IFD's practices had an adverse impact on consumers. (Pet. App. 96a) Indeed, it appears that the Commission found the opposite—no adverse impact on consumers.

2. The Commission determined that dental insurers were neither customers nor competitors of IFD. (Pet. App. 76a)

3. The Commission determined that IFD's practices did not involve exclusion of competitors. (Pet. App. 77a)

4. The Commission failed to determine that there was any actual net impact on the operating costs of insurers or any actual dollar losses to policyholders or employers. In short, since the Commission determined that the evidence failed to establish effectiveness of cost-containment provisions, it likewise determined that IFD's practices had no effect on charges by dentists or insurance premiums. (Pet. App. 88a)

5. The Commission determined the evidence did not establish that patients were deprived of information that would lead them to switch dentists. (Pet. App. 89a, n. 14)

6. The Commission rejected complaint counsels' assertion that competition in the dental insurance market had been harmed. (Pet. App. 87a)

7. The Commission determined that IFD withheld only one aspect of the dentist/insurer transaction, the x-ray. (Pet. App. 76a)

Notwithstanding the foregoing, the Commission applied a rule of reason analysis and decided that:

> IFD's practices substantially limited competition among dentists in their willingness to cooperate with dental insurance cost-containment programs. (Pet. App. 89a)

It is impossible however to determine the markets in which the so called "competition" was substantially limited. The sole reference to market definition is contained in a single footnote in the Commission's decision:

> As in any rule of reason case, attention must be paid to market definition in order to assess competitive effects. No elaborate analysis is required here, since the record shows that under IDA's leadership, the conspiracies span many, if not most, localities in Indiana. Under the leadership of IFD, they continued to be strong in the local areas covered by that organization's three chapters. The record shows no competition from out of state dentists, except in two localities near Louisville, Kentucky. (Pet. App. 85a)

4. *The Decision of the Court of Appeals*

On appeal to the Court of Appeals for the Seventh Circuit, the Court held that a rule of reason analysis was appropriate. The Court recognized that:

> [A]ccording to the evidence presented at the administrative hearing, the IFD member dentists adhered to the legal, moral and ethical policy of quality dental care, requiring that insurers examine and review all diagnostic and clinical aids before formulating a proper course of dental treatment. (Pet. App. 44a).

Additionally, the Court of Appeals found:

> . . . Under a rule of reason analysis, the evidence presented at the Administrative Hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a rele-

vant market, in violation of the Federal Trade Commission Act § 5. (Pet. App. 45a)

The Court further decided that the Commission's market analysis was inadequate:

> The record contains no substantial evidence nor thorough analysis of the total number of dental patients within the relevant market; the percentage of dental patients covered by group dental care plans within the relevant market; the availability and proximity of dentists from surrounding areas of Indiana; the fees charged those patients covered by group dental health care plans, as compared to the fees charged patients without such coverage, within the relevant market; the policy of non-IFD member dentists in dealing with group dental health care insurers within the relevant market; or the general policy of dental insurers throughout the State of Indiana in examining a proposed or completed course of dental treatment for purposes of benefit determination. (Pet. App. 38a)

In its Brief to the Seventh Circuit, the Commission virtually conceded the absence of market definition by stating:

> If the record does fail to establish competition among dentists with respect to their dealings with dental insurers that failure is itself eloquent testimony of the success of the IFD and IDA conspiracy. The absence of such competition, far from negating the existence of a demand for such competition, rather reinforces other evidence showing a conspiracy to prevent it. . . . (J.A. 190)

Based primarily upon record deficiencies, the Seventh Circuit Court of Appeals ultimately decided that:

> The record contains no substantial evidence to support a finding that adherence to the IFD policy had an anticompetitive effect among dentists in their policy of dealing with group dental health care insurers. (Pet. App. 44a-45a)

Senior Judge Fairchild's concurring opinion (an opinion the Commission ostensibly finds tenable) similarly concluded:

> Pretty clearly, no evidence was developed on the validity of an assumption that a dentist's policy of refusal or cooperation has any significance in competition among dentists, and the FTC decision fails to analyze the proposition. It may well be that evidence could be produced to support a finding that this policy is really an element of competition among dentists and that a concerted policy of refusal does work a real injury to competition. But this analysis has not been made. (Pet. App. 49a)

SUMMARY OF THE ARGUMENT

Contrary to the theme of the Commission's Brief, this case should not be regarded as part of a crusade to lower health care costs. In fact, the government has declined to even try to demonstrate that the x-ray submission requirements imposed by the insurance companies on dentists actually lowered costs and benefited patients. With considerable justification, the IFD membership believed strongly that these requirements did *not* reduce costs and that they likely had adverse effects on the quality of dental care provided to patients.

Rather, the focus of this case should be on the proper application of the rule of reason to a non-price restraint promulgated by an association of health care professionals. The Commission purports to quarrel with the Court of Appeals' supposed reweighing of the record evidence. However, its core dispute is with the Court's consideration of "quality of care" factors in applying the rule of reason and its insistence upon a full competitive analysis before condemning the non-price ethical restraint at issue.

1. "Quality of care" factors should be considered in applying the rule of reason to non-price restraints prom-

ulgated by health care professionals. Prior decisions of this Court quite clearly indicate that horizontal restraints by professional associations affecting price may not be justified by noneconomic factors. However, these decisions preserve the possibility that non-price restraints by professional organizations may be justified on the basis of noneconomic factors such as ethical norms and health and safety considerations. In doing so, these cases recognize the fact that the policy of unfettered competition enshrined in our antitrust laws is, and always has been, sufficiently flexible to accommodate noneconomic social and ethical values such as patient care, quality, and safety. Above all, the antitrust laws are designed to maximize consumer welfare. In this case, the Commission ignored the welfare-enhancing factors underlying IFD's restriction on x-ray submissions. Instead, the Commission misread this Court's decision in *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), and held that the rule of reason cannot accommodate quality of care factors in non-price cases.

2. Contrary to the government's bald assertion that "no elaborate analysis" is required (Pet. Br. at 26), the Commission had the burden of proving that the restraint at issue in this case had a substantial adverse impact on competition in defined product and geographic markets. Under well-settled principles reemphasized in *Jefferson Parrish Hosp. Dist. No. 2 v. Hyde*, —— U.S. ——, 104 S. Ct. 1551 (1984), the Commission was required to show an actual effect on some type of competition in defined product and geographic markets. The Commission did not even try to adhere to this traditional standard of proof. It never defined relevant geographic markets. It never delineated the product market in economic terms. It completely ignored any consideration of barriers to entry. And the Commission failed to establish any adverse impact on competition within any market.

ARGUMENT

Although the Commission vigorously complains about the Court of Appeals' supposed reweighing of the evidence in this case, it is patently evident that the Commission's actual dispute is with the legal standard applied by that Court in concluding that the Commission had failed to demonstrate an antitrust violation under the rule of reason. (Pet. App. 34a) Thus, not only does the Commission repeatedly denounce the Court's reliance upon non-economic "legal, ethical and moral" considerations, but it bluntly asserts that "no elaborate analysis is needed to show the anticompetitive effects of the dentists' agreement at issue here." (Pet. Br. 26)

The plain fact is that the Commission, after rejecting application of the *per se* rule, simply concluded that IFD's actions were presumptively anticompetitive absent proof of procompetitive benefits. *See*, D. Clanton, *F.T.C. and the Professions*, 52 Antitrust L.J. 209, 217 (1983). But in its haste to avoid the type of rigorous analysis traditionally required by the rule of reason, the Commission failed to properly consider quality of care justifications, and failed to demonstrate an actual adverse impact on competition in relevant markets. Stripped of rhetoric, the Commission's fundamental position before this Court is that it was not required to undertake such an analysis in this case.[8] That position should be rejected.

I. THE COMMISSION FAILED TO ANALYZE IFD'S NON-ECONOMIC PATIENT CARE JUSTIFICATIONS

Unlike the cases this Court has previously considered involving application of the antitrust laws to the conduct of professionals, this case does not involve restraints on

[8] The Commission's position was highlighted in its Petition for Rehearing in the Court of Appeals: "There are some forms of competitive behavior that, even though subject to examination under the rule of reason, may nevertheless be recognized as anticompetitive 'in the twinkling of an eye' . . . This is such a case." (p. 9)

price competition. Furthermore, although the Government suggests that the Commission's rejection of the *per se* rule in this case was based on its desire to consider the procompetitive benefits related to the ethical and public service justifications advanced by IFD, (Pet. Br. 13-14) the Commission in fact rested its rejection of the *per se* rule on specific findings that the conduct at issue: (1) was "not wholly motivated by an anticompetitive purpose", (2) was "not aimed principally at excluding competitors", and (3) involved only a limited refusal to submit x-rays, rather than all significant aspects of the dentist/insurer transaction. (Pet. App. 76a-77a). Under these circumstances IFD contends that in applying rule of reason analysis to a non-price restraint by health care professionals, the Commission was required to consider quality of care justifications. The ALJ came close to understanding this when he noted in passing:

> The question is . . . whether a noncompetitive factor . . . may be weighed in the balance. Specifically, the claim here is that the boycott in question promotes the health and safety of Indiana citizens by preventing insurers from reducing insurance benefits below proper levels, thereby, as a practical matter, it is alleged, probably preventing an unhealthy reduction in actual treatments too. (Pet. App. 230a)

The Commission essentially concluded that only demonstrably procompetitive benefits may ever justify a professional restraint, even one intended to encourage and maintain widely recognized standards of professional care and treatment. Such a rule, if adopted, would deprive the lower courts of the flexibility essential to evaluate the broad range of professional standards and ethical norms that may be challenged under the antitrust laws, and would require condemnation of all such conduct without regard to any benefits they may promote in terms of public health and safety. The antitrust laws, however, do not require the courts to turn a blind eye to matters of public welfare simply because a particular form of

professional conduct does not necessarily promote the economic interest in competition.

A. Quality of Care Justifications Should Be Considered Under the Rule of Reason

While this Court has repeatedly stated that the learned professions do not enjoy antitrust immunity, the Court also has recognized that professions are not automatically interchangeable with other business activities. Thus, in striking down minimum fee schedules in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), the Court observed:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions concepts which originated in other areas. The public service aspect and other features of the profession may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context be treated differently. We intimate no view on any other situation than the one with which we are confronted today. 421 U.S. at 788-89, n. 17

Similarly, in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 696 (1978), this Court again noted:

> . . . professional services may differ significantly from other business services, and accordingly, the nature of the competition in such may vary. Ethical norms may serve to regulate and promote this competition and thus fall within the rule of reason.

See, Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). While this Court rejected proffered ethical justifications for the particular restraints at issue

in *Goldfarb*, *Professional Engineers*, and *Maricopa*, each of these cases involved direct restraints upon price competition, traditionally analyzed under the *per se* rule. This Court has repeatedly emphasized that price fixing cannot be justified by ethical or other non-economic considerations involving health, safety, or public welfare.

But this case involves a restraint far different than the price restraints examined in prior decisions of this Court. This case involves conduct by health care professionals predominantly motivated by non-frivolous patient care concerns that have no impact on the price of dental services or on price competition among dentists. The proper application of the rule of reason in such a case has not yet been delineated by this Court.

The Commission's attempt to analogize the instant case to the competitive bidding restraint at issue in *Professional Engineers* is flawed for two reasons. *First*, while the Commission argues that the IFD supposedly "precluded sellers from supplying buyers with information they perceived as useful in deciding whether to purchase and how much to pay" (Pet. Br. 26), the Commission fails to delineate who the "buyers" are. If "buyers" is meant to refer to the patients, the reference ignores the fact that the Commission specifically declined to find that patients were deprived of information that would lead them to switch dentists. (Pet. App. 89a, n.14) If "buyers" is a reference to insurers, the Commission overlooks its own concession that insurers have no proper role in determining whether a patient should obtain dental treatment.[9] (Pet. Br. 40) *Second*, unlike *Professional Engineers*, which involved an absolute ban on all price information, the instant case involved a very limited refusal to cooperate with only one aspect of the insurers' claims processing procedures.

[9] Petitioners rely on *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F. 2d 922 (1st Cir. 1984), cert. denied #84-1353 (April, 15, 1985), and *Pennsylvania Dental Association v. Medical Services Association*, 745 F. 2d 248 (3rd Cir. 1984), cert. denied #84-1296, where insurers were essentially customers buying bulk health services from subscribing providers, and then selling these services to their insureds. Here, patients select and purchase from the dentist of their choice. Even the Commission concedes that insurers were not customers. (Pet. App. 76a)

Lower courts have rejected the contention that non-price ethical restraints must be uniformly condemned under the Sherman Act unless demonstrably procompetitive. The Seventh Circuit Court of Appeals in *Wilk v. American Medical Ass'n*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 104 S. Ct. 2398 (1984), considered an antitrust challenge by chiropractors against the American Medical Association for combining to eliminate the chiropractic profession and stated:

> If it should be determined eventually in this case that the Sherman Act was violated, that determination should not rest on insistence that the Act is indifferent to, or even hostile to, the value of permitting medical doctors to honor in their practice what they perceive to be scientific method, or indifferent to or hostile to the value of encouragement, from within the profession, to its members to honor scientific method by declining to associate with those thought to dishonor it. *A value independent of the values attributed to unrestrained competition must enter the equation.* The reasonableness of any resulting restraint on competition must be determined by a reconciliation of values of differing kinds. *To provide the flexibility necessary to analyze a wide range of professional restraints, proper application of the rule of reason in the context of a non-price ethical restraint requires a careful balancing of the legitimacy of the justification offered and the significance of the actual impact on competition.* 719 F.2d at 227 (Emphasis supplied)

Other Courts have recognized that, as the rule of reason might imply, the reasonableness of a non-price restraint

in the context of health care concerns requires a careful balancing of values of different kinds. *See, Wilk, supra.* Courts below have recognized, for instance that *per se* rules otherwise applicable should be tempered in recognition of the ethical and public service obligations of the professions involved. *See Pontius v. Childrens Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982), and *McElhinney v. Medical Protective Co.*, 549 F. Supp. 121 (E.D. Ky. 1982) (cases involving denial of hospital staff privileges). In *Kreuzer v. Am. Academy of Periodontology*, 735 F. 2d 1479 (D.C. Cir. 1984), the Court was asked to resolve an antitrust challenge to a "limited practice requirement" imposed by an association of health care professionals. In so doing, the Court considered the American Academy of Periodontology's argument that the group boycott in question served to advance a desirable social goal unrelated to the group's economic interests. In short, the Court recognized the Academy's argument that the limited practice requirement improved the quality of care of periodontology patients even though it did not necessarily promote competition. In applying the rule of reason, the Court adopted the following balancing test:

> When the economic self-interest of the boycotting group and its proffered justifications merge, the rule of reason will seldom be satisfied. When, however, the justification for the boycott is closely related to a lawful purpose the rule of reason will generally be satisfied. *Id.* at 1494.

Because of the nature of their profession, special duties of loyalty, patient care, and public welfare are imposed upon health care providers. Analysis under the rule of reason in cases where no impact on price is demonstrated should necessarily involve a balancing of these health care concerns. The Court in *Wilk, supra*, delineated factors that should be considered in balancing quality of care concerns against a demonstrative anticompetitive effect:

> 1. That they (health care providers) genuinely entertained a concern for what they perceive as scientific method in the care of each person with whom they have entered into a doctor/patient relationship.
>
> 2. That this concern is objectively reasonable.
>
> 3. That this concern has been the dominant motivating factor . . .
>
> 4. That this concern for scientific method and patient care could not have been adequately satisfied in a manner less restrictive of competition. 719 F. 2d at 227.

Understandably, not all restraints should be upheld merely because ethical considerations are proffered. A balancing is required and each case must turn on its own facts. If the alleged restraint at issue has a substantial impact on competition (such as a total ban) then patient considerations would need to be extremely compelling to prevail (if at all). However, if only a *de minimis* impact on competition is demonstrated, then valid quality of care concerns should prevail.

B. The Commission Failed to Consider IFD's Quality of Care Justifications

The fundamental principle underlying the conduct at issue here is undisputed: the use of a single diagnostic aid, here the x-ray, is wholly inadequate to effect diagnoses and determine adequate dental treatment. As previously delineated, the experts all agree that diagnoses cannot be effected based solely on the use of an x-ray. The ALJ found that the use of a single diagnostic aid, the x-ray, is not enough for an accurate diagnosis. (Pet. App. 238a) The State of Indiana, acting through the Board of Dental Examiners, specifically warned dentists that the submission of x-rays to dental insurers employing unlicensed, incompetent personnel violated Indiana dental law. (J.A. 140-145).[10] The work rule of IFD was en-

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[10] In rejecting IFD's state action defense, the Commission found unpersuasive an adequately evidenced policy by the State of Indiana

dorsed by professionals in the area of dentistry, and was consistent with American Dental Association ethical considerations. (Pet. App. 22a, J.A. 53)

In short, the record is replete with objective medical evidence demonstrating that diagnosis and treatment planning cannot be effected solely through the use of the x-ray. In an attempt to avoid this evidence, the Commission argues that insurers merely use the x-rays for claims review purposes and not for diagnosis. (Pet. Br. 40). But, the Commission also argues that the claims review process was designed to separate "clearly justified" claims from those warranting further scrutiny, and to allow insurers to reject "unnecessary" treatments. (Pet. Br. 4, 24, n. 16) Obviously, determining what treatment is "justified" and what is "unnecessary" is the very essence of a medical diagnosis. Thus, however the Commission wishes to phrase it, the insurers were in fact, improperly making diagnoses.

Nevertheless, the Commission rejected IFD's proffered justifications on the ground that IFD failed to prove that any patients had actually been injured or that any dentist was actually providing substandard care. (Pet. Br. 41). In effect, this means that the medical profession cannot assert patient care concerns unless and until their patients have been injured or doctors commit malpractice. Hopefully, a body count will not be required before health care concerns are considered in a proper rule of reason analysis.

Alternatively, the Commission urges that patient care was not the predominant concern of the IFD. According to the Commission, "the express economic purposes of the

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to preclude the very actions insurance companies insisted upon. (Pet. App. 251a-258a, J.A. 140-145, 154, R. 449-50). Assuming arguendo that the state action defense is unavailable in this case, the State's view of professional conduct further evidences the objective reasonablenss of the IFD dentists' quality of care beliefs and motives.

boycott belie any argument that the boycott can be justified on ethical grounds." (Pet. Br. 41) The Commission's current argument vastly exeeds the findings established in the Commission's decision—at most, the Commission found mixed subjective motivation. (Pet. App. 76a-77a)

Moreover, it is important to recognize that IFD did not seek or accomplish a total refusal to deal with insurers: only the x-rays were withheld from unqualified lay examiners. Had the IFD for economic purposes intended to entirely thwart claims processing, a *total* refusal would have been called for. Instead, the least restrictive method of preventing improper diagnoses was for IFD to withhold the diagnostic aid being abused, the x-ray.

The instant case involves at best, non-price ethical restraints. The Commission failed to properly consider the clear quality of care objectives evidenced by IFD. Thus, the Commission's rule of reason analysis was inadequate.

II. THE COMMISSION FAILED TO DEMONSTRATE ANY ACTUAL ADVERSE IMPACT ON COMPETITION IN A RELEVANT MARKET

The Commission candidly recognizes that this Court has placed responsibility for determining substantial evidence questions in the Court of Appeals, and "will intervene in only what ought to be the rare instance when the [substantial evidence] standard appears to have been misapprehended or grossly misapplied." *American Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490, 423 (1981) (Pet. Cert. 9) The Court of Appeals, cognizant of its role in determining whether substantial evidence exists to support an agency decision, stated:

> In our review of the Commission's Order we are guided by the congressional language of 15 U.S.C. § 45(c) (1982), that ([t]he findings of the Commission as to the facts, if supported by evidence, shall be conclusive.) According to the settled law in this Cir-

> cuit, the Commission (may draw reasonable references from the record). *Spiegel, Inc. v. F.T.C.*, 540 F. 2d 287, 293 (7th Cir. 1976) (Citing, *Consolo v. Federal Maritime Commission*, 383 U.S. 607, 620 (1966). (Pet. App. 28)

The Seventh Circuit essentially concluded that the Commission's truncated analysis of the competitive effects of IFD's alleged restraints was built upon a series of conclusory assumptions about the relevant market, that were not supported by substantial record evidence. In *Jefferson Parrish Hosp. Dist. No. 2 v. Hyde*, —— U.S. ——, 104 S. Ct. 1551 (1984), this court re-emphasized well established principles pertaining to the burden of proof in rule of reason cases. In short, the Commission is required to demonstrate an *actual* effect on competition in defined product and geographic markets. The Commission failed to carry this burden.

A. The Commission Failed to Establish the Existence of Competition in a Relevant Market

The Court of Appeals determined that the record failed to disclose that IFD dentists within the three geographic areas in fact engaged in any form of competition in their policy of dealing with insurers or in complying with the insurers' x-ray directive. (Pet. App. 38a) This is a fundamental shortcoming because there can be no adverse effect on competition unless there is some cognizable kind of competition being affected. In an effort to correct this evidentiary deficiency, the Commission now contends that it was relieved of its burden of proof as a result of concessions supposedly made in various briefs filed by IFD. This argument is without merit. IFD's appeal brief to the Commission clearly demonstrates that IFD urged a *proper* rule of reason analysis:

> Indeed, the instant case involved unique and novel relationships which must be analyzed in terms of their *actual effect on competition and trade* . . . The initial decision fails completely to deal with the

> essential question of whether the so-called boycott by IFD members, had any restraining effect on competition anywhere. (J.A. 177-178)

In an after-the-fact attempt to evidence competition among dentists in their policy of dealing with insurers the Government urges that there is "strong buyer demand for dentists to provide x-rays to insurers." (Pet. Br. 27) This is apparently so because patients want dentists to cooperate with insurers' requests for x-rays so that the desired dental care may be obtained. (Pet. Br. 27) The dentist, so the argument goes, has a strong economic incentive to satisfy these unproven demands of patient and insurer because failure to do so supposedly could cause the patient to take his business elsewhere. (Pet. Br. 28) But, these unsupported propositions simply *assume* that patients choose dentists on the basis of claims processing convenience. There is no evidence regarding the number or percentage of insured patients who patronize IFD members and, thus, no empirical evidence of patient demand. Uninsured patients may be entirely indifferent to, or even in agreement with, IFD's work rule. Insured patients may likewise be indifferent to the dentist's policy if, for example, the patient selects his dentist on the basis of providing quality dental care or if the claim would not exceed the deductible amount in the plan so that the patient would be liable for the full amount in any event.[11]

The Commission's contention that there are strong economic incentives for individual dentists to satisfy the demands of patients and insurers is similarly flawed. (Pet. Br. 28) First, as the Court of Appeals noted, these alleged "incentives" were not delineated. (Pet. App. 40a). Second, if for example, uninsured patients comprised a significant portion of a dentist's practice, or if a dentist's patients agreed with IFD's policy, the dentist would have

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[11] Metropolitan Insurance Company required x-rays for every single dental claim despite the fact that if the claim did not meet the deductible the employee would pay anyway. (J.A. 34)

little or no economic incentive to comply with the insurers' demands. Finally, even if some economic incentives did exist for some dentists, the Commission failed to analyze to what extent these incentives might be offset by economic disincentives such as increased processing costs or legal disincentives such as fear of malpractice claims or disciplinary actions under Indiana state dental law. (J.A. 140-145, 57)

B. The Commission Failed to Establish Relevant Geographic Markets

It is an elementary proposition of antitrust law that the government must establish the existence and boundaries of geographic markets within which to assess the effect of an allegedly restrictive practice. The Commission did not even attempt to establish the contours of relevant geographic markets.[12]

Neither a static nor a dynamic analysis was attempted, and no patient flow data was ever introduced. *See, e.g. In re Hospital Corporation of American*, 3 Trade Reg. Rep. (CCH) ¶ 23,301 (FTC, Oct. 25, 1985). Indeed, the Commission's entire analysis of the relevant market is contained in a single footnote within the Commission's opinion:

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[12] The Commission also failed to define a relevant product market. In the Commission's Brief to the Seventh Circuit, the Commission offered the following explanation for the absence of market definition:

> ". . . Any fair reading of the Commission's opinion shows that the Commission focused upon a market that consists of dental services and competition among dentists in the offering of dental services . . . When the Commission concluded that [s]uch concerted activity by competitors resulted in reducing or eliminating competition among dentists as to their policy of dealing with third party payers . . . the Commission was merely describing the particular aspect of the dental services market that has been injured by IFD's activity." (J.A. 189 n. 26)

> As in any rule of reason case, attention must be paid to market definition in order to assess competitive effects. No elaborate analysis is required here, since the record shows that under IDA's leadership the conspiracy spanned many if not most localities in Indiana. Under the leadership of IFD, it continued to be strong in the local areas covered by that organization's three chapters. The record shows no competition from out of state dentists, except in two localities near Louisville, Kentucky. (Pet. App. 85a, n. 12)

As of February, 1979, the IFD had 84 current members scattered across three parts of Indiana. (Pet. App. 8a) Based only on these membership figures, there is no basis on which to conclude that IFD's three chapters constitute relevant geographic markets for purposes of antitrust analysis. For example, a list of dentists (compiled by United States Administrators) surrounding the Alexandria, Indiana Johns-Manville plant where insured patients were employed, included numerous dentists in Muncie and other localities where IFD had no members. (J.A. 127-136) There is simply no evidence which seeks to define relevant geographic markets in this case.

The Commission ultimately complains that common sense should prevail over hard evidence. (J.A. 27)

The Commission points to a handful of documents supposedly evidencing the fact that certain patients had changed dentists in order to find a complying dentist, and a few instances prior to the formation of IFD where IDA members were concerned with individual dentists submitting x-rays. (Pet. Br. 29-30) These assertions, however, underscore the need for a careful and thorough examination of the market. Thus, if as the Commission's evidence demonstrates, "Indiana patients are being directed to Kentucky to receive their dental treatment by UAW union stewards and Aetna" (Pet. App. 300a), then the relevant market arguably must include nearby Kentucky dentists. The Commission wholly failed to analyze this.

As the Court of Appeals found, the Commission simply failed to establish that dentists competed with one another regarding the submission or non-submission of x-rays. (Pet. App. 37a, 38a) Absent a demonstration of competition *ab initio*, it is difficult to envision how such competition could be diminished.

C. The Commission Failed to Establish Anticompetitive Effects

Not only did the Commission fail to establish competition among dentists with respect to their dealings with third party payers, the Commission wholly failed to demonstrate any adverse impact on competition or consumers.

Justice Brandeis punctuated the Sherman Act's concern for competitive impact in a frequently quoted formulation of the rule of reason test articulated in *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918):

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. *To determine the question* the Court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable; the history of the restraint; the evil believed to exist; the reason for adopting the particular remedy; the purpose or end sought to be obtained, are all relevant facts.

Although the Commission pays lip service to the test delineated in *Chicago Board of Trade, supra*, the Commission failed to consider the factors necessary in determining whether an anticompetitive effect has resulted.

The anticompetitive effect ostensibly observed by the Commission was that concerted activity by competitors (dentists) resulted in reducing or eliminating competition

among dentists as to their policy of dealing with third party payers. (Pet. App. 85a) Instead, the Commission proffered an unsupported conclusion that "patients who were covered by dental plans providing for cost-containment programs such as those here found it difficult to purchase care from dentists who would satisfy the terms of their coverage." (Pet. App. 85a) The record, however, fails to reflect evidence of patient complaints, the number of insured patients involved, or the availability or use of alternatives.

Under the prevailing consumer oriented view of antitrust analysis, the policy of competition is designed for the ultimate benefit of consumers as opposed to individual competitors, and a consumer has no interest in the preservation of a fixed number of competitors greater than the number required to assure his being able to buy at a competitive price. *Marrese v. American Academy of Orthopaedic Surgeons*, 1983-1 Trade Cases, ¶ 65,365 (7th Cir. 1983). It would, at the very least, seem incumbent that the Commission demonstrate that the number of non-IFD members in a local market cannot accommodate insured patients seeking out complying dentists.[13] According to the Commission, the harmful effect of IFD's conduct was to eliminate *incentives* for individual dentists to cooperate with insurers' cost-containment programs. (Pet. App. 40a) But, neither the ALJ nor the Commission delineated the alleged incentives available to dentists for complying with the insurers' x-ray directive. The record fails to disclose any barriers to entry of new dentists in locales where IFD members are situated. Therefore, if demand, competition, and incentives actually do exist, new dentists who will comply would enter the

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[13] The Commission specifically declined a finding of consumer unfairness, (Pet. App. 96a) and rejected a finding that patients were deprived of information that would lead them to switch dentists. (Pet. App. 89a, n. 14)

market and any existing anticompetitive effect would be short-lived and easily corrected by normal market forces.

The refusal at issue here is a very limited one. IFD dentists cooperated with all aspects of dental insurance processing except for the automatic submission of x-rays. IFD dentists also continued to treat insured patients. The actual anticompetitive effects of this very limited refusal are not delineated. Neither the ALJ nor the Commission found that the submission of patients' dental x-rays actually lowered insurers dental costs or that the limited refusal to submit patients' x-rays actually increased dental costs. As indicated previously, the Commission expressly declined to consider these issues. As was the case in *Jefferson Parrish Hosp. No. 2 v. Hyde*, *supra*, at 1568, there is no record evidence of the effect of dentists' x-ray refusal on price, quality, supply or demand. The Commission never demonstrated any price stabilization or price fixing resulting from IFD's limited refusal. At most, patients and insurers may have been inconvenienced primarily as a result of unilateral refusals by dental insurers to pay warranted claims.

In the last analysis, the Commission is likely to echo the recurrent theme of its case—cost-containment. According to the Commission:

> The final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs. (Pet. App. 86a)

But the Commission cannot have it both ways. While the Commission repeatedly contends that cost-containment efforts will be thwarted by an affirmation of the Seventh Circuit, the Commission also contends that they do not have to prove any actual cost-containment. In fact, Commission counsel refused to submit evidence that cost-containment benefits were derived from the insurers' policies. (J.A. 40-41) Consequently, the Commission's

assertion that patients were deprived of cost-containment benefits is entirely speculative.

The Court of Appeals correctly determined that the Commission failed to establish that the conduct of IFD and its member dentists had an anticompetitive effect in any relevant market. (Pet. App. 45a)

CONCLUSION

The Order of the Court of Appeals vacating the Commission's Final Order should be affirmed.

Respectfully submitted,

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BRIEF

(14)

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In the Supreme Court of the United States

OCTOBER TERM, 1985

FEDERAL TRADE COMMISSION, PETITIONER

v.

INDIANA FEDERATION OF DENTISTS

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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FEDERAL TRADE COMMISSION, PETITIONER

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INDIANA FEDERATION OF DENTISTS

ON WRIT OF CERTIORARI TO
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THE SEVENTH CIRCUIT

REPLY BRIEF FOR THE FEDERAL TRADE COMMISSION

We demonstrated in our opening brief that the court of appeals misapprehended and grossly misapplied the substantial evidence standard in overturning the Federal Trade Commission's determination that respondent engaged in an unreasonable restraint of trade. The conspiracy led by respondent to prevent dentists from providing x-rays to insurers plainly reduced competition among dentists, insulating dentists from market forces that create incentives for compliance with insurers' cost containment efforts. Respondent's answering brief and the briefs filed by amici curiae in support of respondent[1] do not refute our position.

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[1]The following entities have submitted briefs amicus curiae supporting IFD: the American Dental Association (ADA); the American Medical Association (AMA), the Physicians and Surgeons Association of Massachusetts (PSAM); and the American College of Radiology (ACR).

We note that the AMA mistakenly asserts that this case was remanded to the Commission by the court of appeals (Br. 20); the court

1. In our opening brief, we observed that this case does not present an occasion for the Court to determine the manner in which antitrust analysis should take account of claims that a restraint of trade is justified on the ground that it promotes quality health care. That question does not arise here because respondent failed to supply *any* factual support for its claim that the ban upon submission of x-rays to insurers was necessary to maintain quality dental care. See FTC Br. 36-43.

All of the amici supporting respondent agree with our conclusion. See AMA Br. 24; ADA Br. 13; PSAM Br. 2; ACR Br. 2. They concede, either explicitly or implicitly, that there simply is no factual support for respondent's quality of care claim.[2] Respondent alone contends (Br. 19-26) that this Court should hold that the conspiracy did not violate the antitrust laws because it promoted quality dental care. However, the Commission correctly concluded (Pet. App. 91a-96a) that the conspiracy was not justified by such quality of care considerations.[3]

Respondent argues (Br. 26) that its conspiracy was necessary to prevent insurers from using x-rays to make medical diagnoses, but, as we discussed in our opening brief (at

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merely vacated the Commission's order and awarded costs to IFD (Pet. App. 51a).

[2]For example, the AMA states that IFD "apparently did not present any evidence that its practices were genuinely intended to promote patient care or that they had that effect" (AMA Br. 24). It is particularly noteworthy that the American Dental Association makes no attempt to argue that IFD's conspiracy was in any way related to maintaining the quality of patient dental care, despite the ADA's obvious familiarity with the relevant medical issues.

[3]Respondent claims (Br. 17) that our dispute is "with the [court of appeals'] consideration of 'quality of care' factors in applying the rule of reason," but the court of appeals did not expressly overturn—or even address—the Commission's factual finding that respondent's conspiracy could not be justified as necessary to promote quality dental care (see FTC Br. 37).

39-40), the diagnosis is made by the treating dentist; the insurer simply evaluates a claim for reimbursement. The patient at all times remains free to select the course of treatment that he desires. Moreover, an insurer denies a claim or awards less than full reimbursement only pursuant to a recommendation by a licensed dentist, who may obtain any information in addition to the x-rays that he deems necessary to form a professional judgment regarding the appropriate treatment (Pet. App. 92a). Thus, there is no support whatsoever for respondent's claim that insurers make medical diagnoses or that insurers' use of x-rays results in inadequate dental care.[4]

Respondent attempts to bolster its claim by citing (Br. 25-26) assorted bulletins, informal pronouncements, and letters issued by employees of various Indiana state agencies as proof that insurance carriers violated Indiana law by using dental x-rays to determine insurance benefits. In considering this same "evidence," however, the Commission found that "none of the documents" cited by IFD supports the proposition that state law forbade insurers from using dental x-rays to make health insurance benefits determinations. Pet. App. 102a; see also *id.* at 98a-102a.[5] Moreover,

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[4]Contrary to respondent's assertion (Br. 26), we do not contend that health care providers must produce a "body count" before health and safety justifications may be considered in antitrust analysis. At the minimum, however, a party must produce at least some evidence supporting an assertion that a challenged restraint serves to promote health or safety before the relevance of such a justification need be addressed. Respondent simply has not supplied any evidence that insurers' use of x-rays in benefits determinations results in inadequate dental care.

[5]The Commission found that the documents cited by IFD were not binding interpretations of state law (Pet. App. 102a-103a). Indeed, the administrative law judge (ALJ) noted in a related context that the "unofficial advisory letter" from the Deputy Attorney General of Indiana (see Resp. Br. 4-5) contained a disclaimer stating that " 'the views expressed herein are those of the writer and are not to be considered to be the opinion of the Attorney General of Indiana nor a precedent of the

even if one could imagine an Indiana policy barring an insurer from using x-rays to determine its contractual liability to pay claims, enforcement of such a policy surely would rest with the appropriate state officials. Respondent has not attempted to explain why the antitrust laws should permit ad hoc enforcement of such a state policy through a conspiracy among competitors motivated in large part by their own economic interests. Cf. *Fashion Originators' Guild, Inc.* v. *FTC*, 312 U.S. 457 (1941).

In view of the lack of evidence supporting IFD's proffered justification for the conspiracy, the court of appeals erred in premising its analysis upon "the fact that the conduct of the IFD member dentists is not designed to drive out competitors but to promote a legal, moral, and ethical policy of quality and proper dental care" (Pet. App. 33a n.15). IFD simply failed to make any threshold showing that its conduct could be justified on ethical grounds.[6]

Attorney General's office' " (Pet. App. 252a-253a (footnote omitted)). The Commission noted that no enforcement action ever had been brought by the State of Indiana against insurers that used x-rays for claims review, and that the relevant legal authority weighed against IFD's contention that insurers' use of lay personnel to grant (but not deny) insurance claims constituted the unlicensed practice of dentistry (*id.* at 100a-101a).

To the extent that IFD's argument is an effort to resurrect its rejected state action defense (see FTC Br. 43 n.35), the documents upon which it relies do not evidence the requisite state policy to supplant competition with regulation. No Indiana regulation governs insurers' review of dental x-rays for purposes of benefits determinations and state officials did not actively supervise the private boycott conducted by IFD. See, *e.g., California Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 105-106 (1980).

[6]IFD argues (Br. 23-25) that, should the Court address the manner in which noneconomic justifications are considered under the antitrust laws, it should adopt the test set forth in *Wilk* v. *AMA*, 719 F.2d 207 (7th Cir. 1983), cert. denied, Nos. 83-1455 & 83-1602 (May 21, 1984). *Wilk* holds that professionals may engage in exclusionary practices directed against competitors when the restraint is motivated principally

2. The Commission analyzed the conspiracy led by respondent under the rule of reason and found that the conspiracy constituted an unreasonable restraint of trade.

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by an objectively reasonable and genuinely held concern for proper scientific method that could not have been satisfied in a manner less restrictive of competition (719 F.2d at 227). To the extent *Wilk* indicates that a noneconomic intent or motive may outweigh a showing of anticompetitive effect, it violates this Court's teaching that antitrust analysis "focuses directly on the challenged restraint's impact on competitive conditions." *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 688 (1978). The appropriate analysis cannot credit bald assertions or unreasonable assumptions that competition is somehow harmful, and it cannot ignore a restraint's anticompetitive effect. Instead, once an agreement has been shown to have an anticompetitive effect, the inquiry should be whether the agreement in fact has counterbalancing procompetitive effects or otherwise promotes economic efficiency. For example, voluntary standards—which are common in the health care industry—frequently might satisfy this test in that they may promote quality without eliminating consumer choice. See FTC Br. 38 n.30.

Jefferson Parish Hospital District No. 2 v. *Hyde*, 466 U.S. 2 (1984), is not to the contrary. The Court held in that case that a tying arrangement subject to rule of reason analysis will be invalidated only upon proof that "the actual effect" of the tie is to restrain competition unreasonably (*id.* at 29). The case thus addresses the showing that a plaintiff must make in order to prove its case. Contrary to the assertion of some of the amici (PSAM Br. 9-10; ACR Br. 9), Justice O'Connor's concurring opinion in that case does not suggest that a restraint is permissible if alleged health care benefits unrelated to competition outweigh its costs. Rather, consistent with the Court's opinion in *Professional Engineers*, the concurrence urges that "[t]he time has * * * come to abandon the '*per se*' label and refocus the inquiry on the adverse *economic effects*, and the *potential economic benefits*, that [a challenged restraint] may have" (466 U.S. at 35 (emphasis added)), and notes that "[t]he ultimate decision whether a tie-in is illegal under the antitrust laws should depend upon the *demonstrated economic effects* of the challenged agreement" (*id.* at 41 (emphasis added)).

In any event, the *Wilk* test is not satisfied here. As we have discussed, IFD's alleged concern for patient care was far from objectively reasonable, and was motivated in substantial part by a desire to shield dentists' incomes from insurers' cost containment programs. See also FTC Br. 39-43.

We showed in our opening brief (at 23-36) that this determination plainly is supported by substantial record evidence.

a. Respondent first contends (Br. 19, 28) that the Commission failed to engage in the analysis necessary to conclude that the conspiracy is unlawful under the rule of reason. The AMA elaborates on this contention, arguing that there exist three mutually exclusive modes of analysis that may be applied in evaluating alleged restraints of trade—per se analysis, "truncated" or "limited" rule of reason analysis, and "full" or "traditional" rule of reason analysis—and that the Commission's decision cannot be sustained under either "limited" or "full" rule of reason analysis. AMA Br. 10-14, 18-30. This argument is based upon a misunderstanding of the standards governing analysis under the rule of reason.

The AMA concedes (Br. 12 n.7) that this Court has not held that there are three distinct standards for analyzing restraints of trade. In fact, the Court has referred to two categories of analysis—per se rules and the rule of reason (see *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 687-692 (1978)), and noted that "there is often no bright line separating *per se* from Rule of Reason analysis" (*NCAA* v. *Board of Regents*, No. 83-271 (June 27, 1984), slip op. 17 n.26). Indeed, several commentators have spoken of a single standard under which restraints are measured on a continuum of reasonableness ranging from inherently anticompetitive at one end to procompetitive at the other.[7]

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[7]See L. Sullivan, *Handbook of the Law of Antitrust* 196 (1977) (the per se rule is a "special case of rule of reason analysis"); R. Bork, *The Antitrust Paradox* 18 (1978); Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, 1982 Sup. Ct. Rev. 319, 329-330; Rahl, *Price Competition and the Price Fixing Rule—Preface and Perspective*, 57 N.W. L. Rev. 137, 139-140 (1962).

Rule of reason analysis is a flexible approach to determining the "reasonableness" of an unending variety of commercial practices that differ greatly in their complexity, purpose, and effect. In some situations, a rule of reason inquiry may entail "an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large whether a particular restraint has been unreasonable" (*Northern Pac. Ry.* v. *United States*, 356 U.S. 1, 5 (1958)). In other circumstances, the rule of reason may allow summary condemnation of an agreement that inherently restrains trade and offers no redeeming procompetitive benefits. *NCAA* v. *Board of Regents*, slip op. 20-21; *Professional Engineers*, 435 U.S. at 692-693; see also *United States* v. *Philadelphia National Bank*, 374 U.S. 321, 362 (1963) ("in any [rule of reason] case in which it is possible * * * to simplify the test of illegality, the courts ought to do so in the interest of sound and practical judicial administration"). The "full rule of reason" and "truncated rule of reason" cited by respondent and the AMA thus are not different tests; they are convenient labels that describe the amount of investigation required "to form a judgment about the competitive significance of [a] restraint." *Professional Engineers*, 435 U.S. at 692; see also *NCAA* v. *Board of Regents*, slip op. 16.[8]

The Court's use of the term "unreasonable" with reference to per se rules also supports this view. See, *e.g.*, *United States* v. *Trenton Potteries Co.*, 273 U.S. 392, 397 (1927) (noting that some restraints are "themselves unreasonable and unlawful restraints without the necessity of minute inquiry"); *United States* v. *Socony—Vacuum Oil Co.*, 310 U.S. 150, 218 (1940) (describing price agreement as an unreasonable restraint of trade).

[8]Invocation of a per se rule represents a finding that a practice may be summarily condemned because it is likely to have "predominantly anticompetitive consequences," *i.e.*, the conduct poses a clear threat to competition *and* there are "generally" no "plausible" procompetitive

The AMA faults the Commission for failing to invoke by name the "truncated rule of reason" (Br. 8-9, 19, 25-26). However, the correctness of the Commission's decision cannot depend upon whether it applied a particular label to its analysis, especially where the basic analytic approach is the same. The question instead is whether the Commission's inquiry was sufficient to ascertain the competitive effect of the restraint.[9] For example, in *NCAA* v. *Board of Regents*, the Court applied a "limited" rule of reason analysis (slip op. 20-26), but never expressly referred to such a standard. The Court stated only that it was analyzing the practices at issue "under the Rule of Reason" because a "fair evaluation of their competitive character requires consideration of the * * * justifications for the restraints" (*id.* at 16). The Court

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justifications that require further scrutiny. *Northwest Wholesale Stationers, Inc.* v. *Pacific Stationery & Printing Co.* No. 83-1368 (June 11, 1985), slip op. 10. Naked price-fixing is the most notable example. See *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332, 351 (1982); *United States* v. *Socony—Vacuum Oil Co.*, 310 U.S. 150, 212-214 (1940). A determination that a per se rule should not be applied, and that a restraint should be analyzed under the rule of reason, is appropriate where the competitive threat is not clear or arguable procompetitive benefits might justify the restraint and require additional scrutiny. The subsequent inquiry under the rule of reason may be elaborate or relatively simple, depending on the evidence of the restraint's anticompetitive effects and potential benefits. This Court's decision in *NCAA* v. *Board of Regents, supra*, demonstrates that a rule of reason inquiry need not be elaborately detailed if initial investigation reveals that the practice poses a threat to competition and is not supported by a valid procompetitive justification. However, if there exist genuine procompetitive benefits to weigh against the threat to competition, the competitive effect of the restraint generally cannot be ascertained without a more detailed inquiry.

[9]This Court has required only that "[t]he agency must articulate a 'rational connection between the facts found and the choice made' * * *. While [the Court] may not supply a reasoned basis for the agency's action that the agency itself has not given * * * [it] will uphold a decison of less than ideal clarity if the agency's path may reasonably be discerned." *Bowman Transportation Inc.* v. *Arkansas-Best Freight System, Inc.*, 419 U.S. 281, 285-286 (1974) (citations omitted).

identified the threat to competition posed by the challenged practices—limiting price competition and output, and frustrating consumer preference—and declared the practices unlawful because they were not justified by any valid procompetitive effect (*id.* at 20-33).

The Commission applied a similar rule of reason analysis here, identifying the threat to competition and considering proffered justifications. As we discussed in our opening brief (at 25-26), the conspiracy at issue in this case resembles attempts by horizontal competitors to dictate the terms upon which they will deal with others (*Paramount Famous Lasky Corp.* v. *United States*, 282 U.S. 30 (1930)) and competitors' efforts to restrict the flow of price-related information (*Professional Engineers, supra*). Since the facts contained in the record before the Commission indicated that the agreement at issue here had a similar anticompetitive effect (see FTC Br. 23-36; pages 11-15, *infra*), the Commission correctly concluded that no elaborate analysis was necessary to find that—absent any procompetitive justification—the agreement constituted an unreasonable restraint of trade (Pet. App. 85a-86a).

Respondent argues that this analysis is incorrect because *Professional Engineers* involved an "absolute ban" on price information while this case concerns only a "very limited refusal to cooperate with only one aspect of the insurers' claims processing procedures." IFD Br. 23; see also AMA Br. 30. In *Professional Engineers*, the conspirators agreed to withhold information about prices until a purchaser tentatively selected an engineer-seller on the basis of reputation or other factors. After an engineer was selected, however, the purchaser could negotiate the price to be charged and select a different engineer if the negotiated price was unacceptable (435 U.S. at 684 n.6). The restraint thus affected the dissemination of price information only to a

limited extent; it required engineers to withhold such information from buyers at the time and in the form buyers deemed price information most desirable in order to further their goal of minimizing the cost of engineering services.

Here, insurers—who ultimately pay for dental services—have concluded that, in order to carry out cost containment policies that were sought by consumers, they require x-rays both to predetermine benefits and decide whether to authorize payment for services already rendered. The conspiracy denies them this important method of obtaining the price-related information they need to review patient claims and efficiently identify claims that require further consideration. Access to x-rays is necessary so that insurers may pay only for the least expensive but adequate care, and avoid paying for unnecessary services. While the conspiracy here is not "price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement" (*Professional Engineers*, 435 U.S. at 692). Thus, the Commission correctly concluded that a more elaborately detailed inquiry was not needed to determine that the conspiracy led by respondent exerted an anticompetitive effect warranting condemnation under the antitrust laws.[10]

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[10]IFD and the AMA also argue that any analogy to *Professional Engineers* is inappropriate because the Commission declined to find that the conspiracy denied patients information that might have led them to switch dentists (IFD Br. 22; AMA Br. 29-30). However, the portion of the Commission's opinion upon which IFD and the AMA rely (Pet. App. 89a n.14) addressed a minor argument raised by the Commission's complaint counsel, that by depriving insurers of x-rays, the conspiracy denied consumer-insurer feedback about the reasonableness of dental charges that might lead consumers to switch dentists (see Complaint Counsel's Brief to the Commission 26). The Commission's refusal to elevate this tertiary argument of complaint counsel to an independent basis for condemning the conspiracy is in no way

b. Respondent claims (Br. 27-35) that the record does not contain facts necessary to support the Commission's determination, but the record is replete with evidence demonstrating that the Commission correctly applied the legal analysis discussed above (see pages 5-10, *supra*) to conclude that the conspiracy led by respondent constituted an unreasonable restraint of trade. IFD does not dispute that, *e.g.*, (1) the statewide Indiana Dental Association and its members, who comprised 85% of licensed Indiana dentists, engaged in a collective refusal to submit x-rays to insurers for claims review;[11] (2) by early 1975 most dentists in

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inconsistent with its other findings regarding the effects of IFD's information restraint upon competition among dentists. Thus, the Commission specifically found (Pet. App. 85a) that the refusal to provide x-rays "reduc[ed] or eliminat[ed] competition among dentists as to their policy of dealing with third-party payers" and "thwart[ed] the efforts of individual insurance companies to contain costs by offering coverage for only the least expensive adequate course of treatment" (*id.* at 83a). It concluded that "[t]he final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs" (*id.* at 86a).

The AMA also argues (Br. 29) that our reliance on *Paramount Famous Lasky* is misplaced because the insurer cannot be equated with the buyer of dentists' services. However, as we discussed in our opening brief (at 24-26), the Commission found that "[t]he insurers broadly represent the economic interests of the dentists' patients" (Pet. App. 228a). The present situation therefore cannot meaningfully be distinguished from the conspiracy to dictate terms to purchasers held to be unlawful in *Paramount Famous Lasky*.

[11]Compare FTC Br. 5-6 with IFD Br. 6 & n.6. Moreover, contrary to the suggestion of the AMA (Br. 22), the Commission did find that the conspirators used coercion to enforce adherence to the conspiracy. During the IDA phase of the boycott the threat of censure was invoked and dentists reported they did not submit x-rays to insurers because they were fearful of retaliation (see Pet. App. 83a, 179a). And, as the Commission noted, an express purpose of IFD was to intensify this sort of pressure. IFD's by-laws contemplated discipline of IFD members by censure, fines, suspension, or expulsion for "any action detrimental to the welfare of the organization" (*id.* at 217a; J.A. 62-63), and IFD's Executive Committee considered the circumstances under which IFD

Indiana were refusing to submit x-rays to insurers;[12] (3) IFD in large part was formed to continue this concerted action when IDA's enthusiasm for the conspiracy waned because of concern about antitrust liability;[13] (4) IFD's first president acknowledged dentists' strong economic interest in withholding x-rays when he was a leader of the IDA phase of the conspiracy;[14] (5) one of IFD's first actions was to adopt a work rule barring IFD members from sending dental x-rays to insurers who requested x-rays for purposes of claims review and cost containment;[15] (6) a solid majority of dentists practicing in the area covered by IFD's Anderson and Lafayette chapters were members of IFD;[16] and (7) IFD members refused to send x-rays to insurers.[17] These facts surely are sufficient to show that IFD's conspiracy had an anticompetitive effect.

IFD first argues (Br. 28-30) that there is no evidence in the record to support the Commission's conclusion that providing x-rays to insurers was an element of competition among dentists. In fact, as we demonstrated in our opening brief (at 27-31), documentary evidence clearly establishes that dentists were aware of competitive pressure to supply x-rays to insurers and that dentists in fact competed for

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would seek (although "only as a last resort") to "discipline, or [undertake] acts of reprisal against non-member dentists and dissident members" (Pet. App. 220a; J.A. 120).

[12]See FTC Br. 6. IFD's brief is silent on this point.

[13]Compare FTC Br. 6-7 with IFD Br. 7.

[14]Compare FTC Br. 5 with IFD Br. 27.

[15]Compare FTC Br. 8 with IFD Br. 7-8, 11.

[16]Compare FTC Br. 9, 32 & n.24 with IFD Br. 31.

[17]Compare FTC Br. 8, 11-12 with IFD Br. 11.

patients with respect to this aspect of cooperation with insurers.[18]

IFD next argues (Br. 30-32) that the Commission's determination cannot be upheld because the Commission did not describe with precision the geographic market affected by the conspiracy. IFD complains that the record does not include "evidence regarding the number or percentage of insured patients who patronize IFD members and, thus, no empirical evidence of patient demand" (IFD Br. 29) and that "to establish the contours of relevant geographic markets * * * [n]either a static nor a dynamic analysis was attempted, and no patient flow data was ever introduced" (*id.* at 30 (footnote omitted)).

IFD's complaints are unfounded. The types of evidence identified by IFD would be probative in defining a relevant market, but such evidence is not the only means of determining that dentists compete among themselves with respect to submission of patient claims information to insurers or that an agreement by dentists not to compete with respect to x-ray submission affects competition in the communities in which the dentists practice. "[W]here the anticompetitive effects of conduct can be ascertained through means short of extensive market analysis, and where no countervailing competitive virtues are evident, a lengthy analysis of market power is not necessary.' " *NCAA* v. *Board of Regents,* slip op. 23-24 n.42; see also *Professional Engineers,* 435 U.S. at 695.

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[18]The AMA complains (Br. 23) that the documentary evidence discussed in our opening brief was not identified in the Commission's opinion. Of course, the reason that some of the record evidence cited in our brief was not discussed in the Commission's opinion is that the proposition for which these documents are cited was conceded by IFD in its briefs before the Commission (see FTC Br. 28). No principle of administrative law requires an agency to cite repetitive documentary evidence to support a self-evident proposition that is unchallenged by any of the parties to an administrative proceeding.

The Commission found that IFD's conduct was the continuation of a statewide conspiracy begun by IDA, the state dental association, and that IDA and IFD had the market power to make their boycott effective, with IDA's membership including 85% of all dentists licensed in Indiana, most of whom participated in the boycott (Pet. App. 151a-152a, 172a-175a).[19] In continuing IDA's statewide conspiracy, IFD achieved substantial majority participation among the practicing dentists in Madison County and in the area covered by its Lafayette Chapter. Pet. App. 39a-40a, 84a-85a; J.A. 124; see FTC Br. 32 n.24. Given the broad scope of the initial boycott and its evident economic purposes and effect, no further analysis of the geographic market was required to determine that IFD's conduct had an impermissible anticompetitive effect. See *NCAA* v. *Board of Regents,* slip op. 23-24 & n.42; compare *Paramount Famous Lasky Corp.* v. *United States,* 282 U.S. at 44.

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[19]This evidence alone resolves any question regarding the existence of market power. It is a settled principle of antitrust law, noted by the Commission in its opinion (Pet. App. 78a n.11) and not disputed by IFD or the court of appeals, that persons joining a preexisting antitrust conspiracy with knowledge of the prior unlawful conduct and with the intent to pursue the same unlawful objective are civilly liable for all conduct in furtherance of the conspiracy, including the acts that occurred before they joined the conspiracy. *Hays* v. *United Fireworks Manufacturing Co.,* 420 F.2d 836, 844 (9th Cir. 1969); *Dextone* v. *Building Trades Council,* 60 F.2d 47, 48 (2d Cir. 1932); *In re Nissan Motor Corp. Antitrust Litigation,* 430 F.Supp. 231, 232-234 (S.D. Fla. 1977); *Walder* v. *Paramount Publix Corp.,* 132 F. Supp. 912, 920 (S.D.N.Y. 1955), aff'd, 272 F.2d 349 (2d Cir. 1959), cert. denied, 362 U.S. 952 (1960). Applying this principle, the Commission properly concluded that IFD could be charged with a restraint of trade in a statewide market on the basis of IDA's overwhelming statewide market power; indeed, the express purpose of the formation of IFD was to perpetuate the IDA conspiracy. Pet. App. 85a n.12. A contrary view would mean that even though the Commission could stop the statewide conspirator (IDA) from continuing its unlawful conduct—as the Commission did by means of a consent agreement (Pet. App. 60a n.2)—it would be unable to act against groups organized to continue the conspiracy until such time as those groups regenerated the original restraint of trade on a scale comparable to its original broad scale.

Finally, IFD argues (Br. 32) that "the Commission wholly failed to demonstrate any adverse impact on competition or consumers." IFD complains that "[t]he record * * * fails to reflect evidence of patient complaints, the number of insured patients involved, or the availability or use of alternatives" (*id.* at 33).

However, IFD ignores the ample record evidence establishing that the conspiracy had an adverse effect upon both patients and insurers. The evidence demonstrates that (1) IFD and IDA possessed market power, (2) the conspiracy was motivated by economic purposes, (3) dentists did stop competing to a substantial degree with respect to their policy of submitting x-rays to insurers, (4) insurers incurred substantial costs as a result of the collective refusal to submit x-rays, and (5) patients were unable to engage the services of dentists who would submit x-rays and thus lost the benefit of their insurance contracts. See FTC Br. 9-12. This evidence is more than sufficient to support the Commission's finding of an unlawful anticompetitive effect. See *American Textile Manufacturers Institute* v. *Donovan,* 452 U.S. 490, 522-523 (1981); *Universal Camera Corp.* v. *NLRB,* 340 U.S. 474, 477 (1951).[20]

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[20]IFD also asserts that, in any event, "a consumer has no interest in the preservation of a fixed number of competitors greater than the number required to assure his being able to buy at a competitive price" (Br. 33). But this is simply another way of stating the requirement that a restraint must unreasonably restrict competition. The evidence in the record shows that this requirement is satisfied here, where the conspirators achieved widespread adherence to their agreement. IFD cannot seriously contend that its conspiracy is not unlawful because "new dentists * * * would enter the market and any existing anticompetitive effect would be short-lived" or because a few dentists already in the market might decline to join the conspiracy (Br. 33-34). That rationale would equally suggest abandonment of the per se rule against price-fixing (and compel exhaustive analysis of similar horizontal conspiracies that now may be condemned in more abbreviated fashion) on the ground that any such conspiracy could theoretically be undercut by new entrants or existing market participants who decline to participate.

For the foregoing reasons and the reasons stated in our opening brief, the judgment of the court of appeals should be reversed and the case remanded with instructions that the court affirm and enforce the order of the Commission.

Respectfully submitted.

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AMICUS CURIAE

BRIEF

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IN THE

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OCTOBER TERM, 1985

FEDERAL TRADE COMMISSION,
Petitioner,

v.

INDIANA FEDERATION OF DENTISTS,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF REVERSAL

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BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF REVERSAL

INTEREST OF AMICUS CURIAE

The Health Insurance Association of America ("HIAA") is a not-for-profit trade association of more than 300 private insurance companies.[1] HIAA's member companies collectively account for approximately 85 percent of the health insurance written by private insurance companies in the United States.

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[1] HIAA is incorporated in the State of Delaware and its principal office is in Washington, D.C.

As part of their overall health insurance business, HIAA member companies sell large amounts of group dental insurance to sophisticated and demanding buyers, including many of the nation's largest employers. Given the very competitive environment which exists in this marketplace, HIAA member companies have a strong interest in ensuring that dental claims are processed expeditiously and paid correctly. These companies have a similarly strong interest in dental insurance cost containment efforts, directed toward meeting consumers' demands for the widest possible coverage at the lowest possible price.

In processing dental insurance claims involving certain teeth or particular procedures, many HIAA member companies request x-rays from the dentists providing the treatment. Such x-rays are sought to resolve issues of basic coverage, to determine necessity of treatment and appropriateness of care, and to detect fraudulent claims.

Consequently, the issue presented by this appeal—whether a group of dentists can collectively agree to deprive insurance companies of reasonable and meaningful access to dental x-rays—is of considerable concern to HIAA and its member companies. Indeed, several HIAA member companies were directly affected in their operations by the conduct at issue here—the actions of Respondent Indiana Federation of Dentists ("IFD") in orchestrating a group boycott of Indiana dentists who collectively refused to provide dental x-rays to third-party payers.[2] HIAA is especially concerned because it believes that access to dental x-rays is an important element of the review practices of insurers in containing dental costs and promoting competition among dentists.

[2] HIAA's members include Aetna Life and Casualty Co. ("Aetna"), Connecticut General Life Insurance Co. ("Connecticut General"), now part of Cigna, and Metropolitan Life Insurance Company ("Metropolitan"), whose administration of group dental health care plans for International Harvester Company, General Motors Corporation, and Brockway Glass Co. was hampered by the group boycott here. (*See* Pet. App. 6a-7a, 83a-84a).

Accordingly, HIAA and its member companies submit that the United States Court of Appeals for the Seventh Circuit erred in holding that Petitioner Federal Trade Commission ("the Commission") failed to establish that the collective conduct in this case represented an unfair method of competition in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. HIAA, as the national trade association of the private health insurance industry, thus files this Brief as Amicus Curiae in support of reversal of the judgment below. Consent to the filing of this Brief has been obtained from the counsel of record for both Petitioner and Respondent.

INTRODUCTION AND SUMMARY OF ARGUMENT

1. This case arises from the collective refusal of a significant number of competing Indiana dentists, under the leadership of IFD, to provide insurance companies with dental x-rays sought pursuant to cost containment provisions of industrial group dental health care policies. (Pet. App. 61a-62a).[3] To determine the appropriate amount of reimbursement to insured patients (and to prevent fraudulent claims), insurers routinely review the treatment performed by dentists (*id.* at 139a n.4) and, as part of this review, ask that dentists complete claim forms and submit them with copies of existing x-rays and other relevant information. (*Id.* at 61a-62a n.4). This process helps insurers identify those claims that require further scrutiny before payment.

Such review procedures are one part of extensive national efforts to reduce the growing cost of health care

[3] In order to help limit the costs (and price) of insurance, these policies obligate the insurer to pay only for the reasonably necessary expenses of dental treatment. (*Id.* at 61a-62a, 139a-140a).

expenditures, which at present account for almost 11 percent of the gross national product.[4] These expenditures, which are ultimately reflected in the price of all goods and services, affect every member of our society. In an effort to contain such costs, health insurance companies, employers, unions, and community-wide health care coalitions have promoted various cost containment methods. The practices involved here—predetermination of claims[5] and "alternate benefits" provisions[6]—are an important element in controlling the costs of insurance premiums and of overall health expenditures.

2. Under the leadership of the Indiana Dental Association ("IDA") and later, IFD, various Indiana dentists collectively agreed to refuse to provide x-rays to insurers. This group boycott centered around three Indiana communities—Anderson, Lafayette, and Fort Wayne—each of which contained a plant whose employees were insured under an industrial group dental health care plan. (*See id.* at 177a, 188a). The vast majority of the dentists in these areas supported the boycott, and the submission of dental x-rays was significantly reduced. (*Id.* at 85a-86a, 95a-96a).

In response to this boycott, insurance companies were forced to modify their normal practices in processing insurance claims. (*Id.* at 68a-69a).[7] The direct result

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[4] *See* notes 8-9 *infra*

[5] For certain types of treatment (generally more expensive procedures), the insurer may review the insured's eligibility, benefit entitlement, and proposed treatment and inform the patient and dentist in advance of the amount of benefits that will be paid under the insurance policy. (Pet. App. 61a-62a n.4).

[6] Many insurance contracts provide benefit payments to cover only the cost of the "least expensive yet adequate treatment"; if a patient desires more expensive treatment, he must pay the difference out of his own pocket. (*Id.* at 139a n.23, 140a).

[7] For example, Aetna, which had accumulated a backlog of 600 unpaid claims due to its inability to verify benefits through examination of x-rays, retained a licensed dentist as a consultant and sent him, at considerable expense, to the office of each dentist who refused to submit x-rays to review claims with the dentist and to urge submission of x-rays in future. (Pet. App. at 180a-181a). Because of the continuing refusal to submit x-rays, Aetna eventually hired consultants to perform in-mouth examinations of claimants; between 1974 and 1978 Aetna conducted nearly 4700 examinations at an estimated cost of $10 each. (*Id.* at 187a-188a).

of the boycott was that some dental claims were paid late or not at all and insurers' efforts to contain costs by paying only for reasonable and necessary care were thwarted. (*Id.* at 83a).

3. In 1978 the Commission issued an administrative complaint against IFD, charging that its boycott constituted an "unfair method of competition" under Section 5. In an initial decision, the administrative law judge found that the boycott was illegal *per se* and also had substantially injured competition under a Rule of Reason analysis. (*Id.* at 276a). On appeal, the Commission unanimously rejected *per se* condemnation of the boycott, but concluded that it violated Section 5 under a Rule of Reason analysis, since IFD's purported justifications for its conduct were both unproven and insufficient to outweigh the boycott's anticompetitive effects. (*See, e.g., id.* at 85a-86a, 95a-96a).

4. On IFD's petition for review, a panel of the United States Court of Appeals for the Seventh Circuit (Senior Judge Fairchild concurring in the result) held that the Commission had failed to establish that the boycott had any anticompetitive effect. In its opinion, the court also repeatedly characterized IFD's refusal to provide x-rays as the product of a "legal, moral, and ethical" policy to achieve "quality dental care" (*id.* at 38a-44a), despite the lack of any evidence in the record that the submission of x-rays had any effect on the quality of dental care.

5. The issue before this Court is whether the collective refusal of competing dentists to submit x-rays to insurers for use in reviewing insurance claims represents an unfair method of competition. It is clear from the record in this proceeding, as well as simple logic, that this collective refusal of dentists (or group boycott, for that is what it was) did reduce competition between dentists. It is also clear from the record that the boycott had no procompetitive effects. Under this Court's decisions, most recently in *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), such conduct violates the Sherman Act, 15 U.S.C. § 1, and *a fortiori*, the FTC Act as well. The Court of Appeals' contrary decision is clearly erroneous and cannot stand.

6. The court of appeal's empty invocation of "legal, moral, and ethical" considerations as support for its conclusion that the boycott did not violate the antitrust laws represents a troubling and dangerous precedent for future cases involving collective action by health care and other professionals—or anyone else for that matter. Similar claims could undoubtedly be raised with respect to many kinds of collective action by professionals or others that would have very significant anticompetitive effects. This is especially important in the health care industry, which accounts for a growing share of consumer expenditures, but the implications are certainly not confined to that section of the economy.

The standard articulated in *Professional Engineers* limits antitrust analysis under the Rule of Reason to a weighing of competitive effects; by its decision, the court of appeals would allow the inclusion of "legal, moral, and ethical" considerations, a formulation that is inherently unbounded. Unless this Court is prepared to reconsider *Professional Engineers*, the Seventh Circuit's decision must be reversed.

ARGUMENT

I. Because of the Importance of the Health Care Sector to the Overall Economy And the Need for Cost Containment Measures, Anticompetitive Conduct by Health Care Providers Is of Particular Concern.

The issues raised by this case are of particular concern because of the increasing share of this nation's resources that are consumed by health care expenditures. In 1983, the United States spent an estimated $355 billion on health care expenditures, an amount equal to 10.8 percent of the gross national product.[8] Although the rate of growth in such expenditures is projected to moderate somewhat in coming years, it has nonetheless been estimated that health expenditures will reach $660 billion in 1990 and consume over 11 percent of the gross national product.[9]

Expenditures for dental services have similarly grown from $6.5 billion in 1973 to $27.3 billion in 1985.[10] These expenditures are expected to increase to $40.5 billion in 1990.[11] The extent to which such expenditures have been covered by health insurance has also increased dramat-

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[8] *See* Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, 6 Health Care Fin. Rev. 1 (Winter 1984) [hereinafter cited as *National Health Expenditures*]. This represents an expenditure of $1,459 per person in 1983. *Id.*

[9] Arnett, Cowell, Davidoff & Freeland, *Health Spending Trends in the 1980's: Adjusting to Financial Incentives*, 6 Health Care Fin. Rev. 1 (Spring 1985) [hereinafter cited as *Health Spending Trends*]. Thus, by 1990, per capita expenditures for health care are projected to be approximately $2,550. *Id.* at 2.

[10] *Id.* at 13-15.

[11] *Id.* The 1985 rate of increase for dental services was 6.1 percent, compared to an increase in the cost of all goods and services of 3.2 percent. ADA News, Nov. 4, 1985, at 1, col. 4.

ically.[12] In 1973, only $0.5 billion or 7.6 percent of total expenditures for dental services were covered by health insurance; in 1985, $9.4 billion or 34.4 percent of total expenditures were covered.[13]

To contain these expenditures, cost containment efforts have become a significant goal of all participants in the health care industry.[14] In recent years, health insurance companies and employers, among others, have promoted various cost containment techniques.[15]

The health insurance industry has been a leader in cost containment efforts because of the direct relationship of claims expenditures to premium costs. Since insurance companies compete, in large part, based on premiums charged for their coverage, they have strong incentives to reduce the costs of that coverage by eliminating fraud, preventing unnecessary expenditures, and substituting less expensive treatment alternatives.

Employers, who provide the bulk of health insurance through employee health care plans, support such efforts because insurance costs have become a major expense of

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[12] *Health Spending Trends, supra*, at 13-15. Enrollment for dental benefits, largely through employer-sponsored plans, increased by over 50 percent between 1976 and 1979 to a total of 60.3 million covered persons. *National Health Expenditures, supra*, at 12.

[13] *Health Spending Trends, supra*, at 13-15.

[14] Indeed, such cost containment efforts have played an important role in moderating the increases in health care expenditures. *See, e.g., Lassoing Runaway Medical Costs*, Bus. Wk., Oct. 21, 1985, at 146.

[15] These techniques include, among others, audits of medical bills, coordination of benefits, preadmission authorization, concurrent utilization review, peer review of claims, and out-patient surgery. *See, e.g.*, Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 321-25.

doing business.[16] Controlling insurance costs has a direct effect on firms' ability to compete in domestic and international markets.

Consumers also have a direct interest in cost containment measures. Increased costs for health care affect consumers' out-of-pocket expenditures for medical costs not covered by health insurance. Moreover, the cost of health insurance premiums is reflected in the price consumers pay for goods and services. Finally, consumers have a further incentive in reducing health care expenditures to prevent expenditures for higher health insurance premiums from entirely consuming their fringe benefits.[17]

Health care expenditures thus have a direct effect on every citizen. Any collective action by health care providers which reduces competition and frustrates cost containment measures in this sector gives rise to particular concern.

II. Contrary to the Seventh Circuit's Decision, the Commission's Opinion Establishes That the Collective Refusal to Provide X-Rays Violates Section 5.

In reversing the Commission's final opinion and order, the court of appeals concluded that the Commission had failed to present "substantial evidence" of an anticompetitive effect and thus did not establish a violation of Section 5. (Pet. App. 45a). This conclusion ignores the importance of access to dental x-rays in implementing

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[16] For example, despite a year-long campaign to reduce medical costs that saved the company an estimated $58 million, Chrysler Corporation will still spend more than $402 million for medical insurance in 1985, or more than $5,000 for each current employee. This represents a cost of about $275 for each vehicle made by Chrysler. Rosenbaum, *Chrysler Program Saves Millions In Health Costs*, N.Y. Times, Apr. 29, 1985, at B6, col. 3.

[17] The costs of health care are also reflected in the increased taxes paid for Medicare and Medicaid. *See* HIAA, *Rx for Controlling Employee Health Care Costs* 1 (1984).

cost containment programs, the resulting competition between dentists with respect to participation in such programs, and the economic motive and need for collective action underlying the group boycott.

The court's initial error is compounded by its reliance on unsubstantiated assertions of "legal, moral, and ethical" policy considerations relating to "quality dental care" to justify the collective refusal to provide x-rays. This approach reflects a fundamental misunderstanding of the factors appropriately considered under the Rule of Reason, which permits anticompetitive effects to be outweighed only by a showing of procompetitive benefits. No such showing can be made on the record in this case, and thus "legal, moral, and ethical" considerations cannot be invoked to shield IFD's group boycott.[18]

A. Under The Rule of Reason, Conduct Producing Anticompetitive Effects Violates the Antitrust Laws Unless Those Effects Are Outweighed by Procompetitive Benefits.

Both the Commission and the court of appeals concluded that the collective refusal to provide x-rays did not warrant *per se* condemnation, but instead should be analyzed under the Rule of Reason.[19] As this Court has

[18] There can be no doubt that IFD's conspiracy represents a group boycott, which this Court has defined as "a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target." *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541 (1978).

[19] (Pet. App. 32a, 76a). Given the divergent approaches represented by these two methods of analysis, some have mistakenly concluded that all conduct necessarily must either be subject to automatic *per se* condemnation or extensively scrutinized under the Rule of Reason by analyzing all aspects of the conduct and the circumstances in which it arose (*e.g.*, market definition, market power, intent and competitive effect) before its legality can be determined. To the extent that the court of appeal's opinion reflects this view (*see id.* at 33a-35a & n.16), it is contrary to well-established precedent that a "truncated" analysis under the Rule of Reason is

recognized, the purpose of antitrust analysis under either standard is "to form a judgment about the competitive significance of the restraint." *Professional Engineers*, *supra*, 435 U.S. at 692. The test of legality is "whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918); *Professional Engineers*, *supra*, 435 U.S. at 691.

Under the standard set forth in *NCAA v. Board of Regents of Univ. of Oklahoma*:

> [W]hen there is an agreement not to compete in terms of price or output, "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement."

104 S.Ct. 2948, 2965 (1984) (*quoting Professional Engineers*, *supra*, 435 U.S. at 692).[20] Once the anticompetitive effect of a group boycott or other collective action has been established, the proponent of the conduct faces "a heavy burden of establishing an affirmative defense which competitively justifies this apparent deviation from

appropriate if the anticompetitive effect of the conduct under review is clear and the justifications asserted for it will produce little or no competitive benefit. *See, e.g., NCAA v. Board of Regents of Univ. of Oklahoma*, 104 S.Ct. 2948, 2966 n.42 (1984) ("[W]here the anticompetitive effects of conduct can be ascertained through means short of extensive market analysis, and where no countervailing competitive virtues are evident, a lengthy analysis of market power is not necessary.").

[20] The FTC has used a similar "truncated" analysis in other cases involving health care professionals. *See American Medical Ass'n*, 94 F.T.C. 701, 1004 (1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982) ("the contours of the analysis required under the rule of reason will vary somewhat depending upon the nature of the restraint"); *Michigan State Medical Soc'y*, 101 F.T.C. 191, 292 (1983) ("Where horizontal arrangements . . . closely relate to prices . . ., a less elaborate analysis of competitive effects is required.").

the operations of a free market." *NCAA*, *supra*, 104 S.Ct. at 2967. In the absence of a showing of procompetitive benefits that outweigh the anticompetitive effects, the collective action will be found to violate the antitrust laws. *Id.* at 2969-70.[21]

Although such a showing can certainly be made in some circumstances,[22] it is not possible here, where no output-increasing or price-reducing effects have been offered to justify the collective refusal to provide dental x-rays. Moreover, the court's reliance on "legal, moral, and ethical" considerations establishes such an undefined and far-reaching standard that it could be raised to justify almost any type of collective action by professionals (or perhaps anyone).

This is not to suggest that ethical considerations are never appropriately considered under a Rule of Reason analysis. As this Court recognized in *Professional Engineers*,

> [B]y their nature, professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason.

435 U.S. at 696.[23]

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[21] *See, e.g., Smith v. Pro Football, Inc.*, 593 F.2d 1173, 1188-89 (D.C. Cir. 1978) (collective action "can survive scrutiny under the rule of reason only if it is demonstrated to have positive, economically *procompetitive* benefits that offset its anticompetitive effects") (emphasis in original).

[22] For example, a joint selling arrangement may be so efficient that it will increase the sellers' aggregate output and thus be procompetitive. *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 18-23 (1979).

[23] *See also Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 348-49 (1982) ("public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently") (*quoting Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975)).

Thus, for example, a Rule of Reason analysis may support collective action by professionals that is based on a clearly expressed legislative intent to displace competition with regulation,[24] intended to achieve a goal other than the restriction of competition where there is only an incidental affect on competition,[25] or necessary to achieve a procompetitive benefit.[26] It is clear, however, that none of these situations is present here.

B. The Collective Refusal to Provide X-Rays Reflected an Economic Motive.

The claimed "legal, moral, and ethical" considerations that allegedly prompted the group boycott must be assessed in light of the demonstrated economic motive for the collective refusal to provide dental x-rays. The IFD was formed "[t]o represent dentists in all socio-economic

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[24] *See, e.g., National Gerimedical Hospital & Gerontology Center v. Blue Cross*, 452 U.S. 378, 393 n.18 (1981); *Gordon v. New York Stock Exchange*, 422 U.S. 659, 683-86 (1975).

[25] Thus, for example, sanctions imposed by professional organizations against athletes for gambling have been upheld despite antitrust challenges. *E.g., Deeson v. Professional Golfers' Ass'n*, 358 F.2d 165 (9th Cir.), *cert. denied*, 385 U.S. 846 (1966). Similarly, as the Commission hypothesized in its opinion here, "guidelines promulgated by a professional health association recommending the avoidance of a drug discovered to be dangerous could not be considered an antitrust violation in the absence of any purpose to limit competition." (Pet. App. 94a).

[26] For example, adherence to an ethical standard might in some circumstances increase the level of consumer confidence in the service provided and thus increase overall output by promoting a greater demand for that service. *See, e.g., American Medical Ass'n*, 94 F.T.C. 701, 1003 (1979) ("justifications for ethical norms, such as the facilitation of nondeceptive advertising, may be procompetitive and must be taken into account"), *aff'd*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982).

matters, negotiations and grievances with employers, third and fourth parties or any group that is involved in financing or delivery of dental care." (Pet. App. 216a). In a speech to IFD's Council on Dental Care Programs in 1974, Dr. McClure, the First President of IFD, stated:

> We are fighting an economic war where the very survival of our profession is at stake. . . . The name of the game is money.

(*Id.* at 49a).

The economic nature of the boycott was further reflected in numerous evidentiary submissions. For example, a dental society newsletter stated:

> Some Indiana dentists, either in ignorance *or in an attempt to gain economic advantage over their peers*, have been forwarding radiographs to insurance carriers. This unethical practice puts increasing pressure of *a monetary nature* on dentists who practice in the same geographic areas.

(*Id.* at 289a) (emphasis added).

The reasons for this economic concern are also clear. A necessary consequence of the successful implementation of the cost-containment measures involved here would be a reduction in the income of Indiana dentists.[27] The record established that the alternate benefits clause was a significant cost-containing mechanism because, when invoked, it usually meant that "benefits would be paid for a less expensive treatment than proposed." (*Id.* at 140a & n.26). As a result, the administrative law judge concluded, "the economic interest of dentists in not being 'second-guessed' by their patients' insurers is too

[27] As Dr. McClure stated:

> The government and labor are determined to reduce the cost of the dental health dollar at the expense of the dentist. There is no way a dental service can be rendered cheaper when the third party has to have its share of the dollar.

(Pet. App. 80a).

plain to need elaboration." (*Id.* at 139a).[28] This demonstrated economic motive cannot be ignored in assessing the anticompetitive effect of the group boycott.

The economic concerns underlying the group boycott could not be achieved by unilateral decisions by individual dentists, for it is clear that collective action was essential to the success of IFD's efforts. Without a conspiracy, individual dentists would have been subject to competitive market forces, which would create incentives for them to facilitate claims approval by complying with the request to provide x-rays. (*Id.*) In the words of the Commission:

> By colluding, competitor dentists were freed to some extent from these market forces because they knew other participants in the boycott would also refuse to cooperate. Consequently, the dentist-insurer relationship was determined by economic coercion, not by market competition.

(*Id.* at 85a-86a).

Thus, it appears that economic concerns were at least a significant, and probably dominant, motivation for the challenged boycott. This fact necessarily must be considered in evaluating the competitive effects of the boycott.

C. The Collective Refusal to Provide X-Rays Resulted in Demonstrated Anticompetitive Effects.

In holding that the Commission failed to establish that IFD's boycott produced significant anticompetitive effects, the court of appeals concluded that the Commis-

[28] Similarly, in rejecting the relevance of "legal, moral, and ethical" considerations, Judge Fairchild's concurring opinion recognized:

> Insofar as they imply a finding that legal, moral and ethical considerations and approved standards were the sole cause of the concerted policy, they are in conflict with a clearly and adequately supported finding of the FTC of an economic motive.

(*Id.* at 49a).

sion had not proved that dentists compete with respect to the submission of x-rays to insurers. This finding ignores the importance of x-rays to third-party payers such as insurance companies and the evidence of the anticompetitive effects associated with the collective refusal to provide x-rays.

1. *The Availability of Dental X-Rays Is an Important Element of Cost Containment Measures.*

As discussed above, third-party payers such as insurance companies have a strong interest in reducing health care expenditures, and predetermination review and alternate benefits provisions in dental insurance contracts are important elements of this effort. The availability of dental x-rays is essential for the effective operation of such programs. In contrast to many medical procedures, dental procedures for the most part do not arise unexpectedly (thus permitting greater flexibility as to when they are performed), are frequently elective in nature, and often present a range of treatment alternatives, the cost of which can vary significantly. Moreover, dentists are usually the sole provider of the service, again in contrast to medical procedures where physicians, hospitals and other professionals are frequently involved and can serve as a check on each other's performance.

In such circumstances, dental x-rays are often the only or best source of information regarding the necessity for and quality of the services performed.[29] Because x-rays are generally taken prior to treatment, they are available for use in benefit determination. Unlike written reports, which provide no basis for determining whether the report accurately describes conditions, x-rays permit

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[29] In contrast, most medical procedures generate diagnostic records, test reports, and hospital records and bills, which can be used in evaluating the benefits claimed. As a result, employers frequently insist on provision of dental x-rays for review before the claim can be paid. (Pet. App. 86a).

dental consultants to obtain first-hand knowledge of the insured's dental condition. As a result, they are a necessary starting point for making determinations with respect to the need for and appropriateness of the dental treatment.

Given the large number of dental claims generated, submission of x-rays is one of the most effective means of reviewing such claims. Alternatives such as office visits to examine x-rays or in-mouth examinations are generally impractical because of the greater time and expense involved.[30]

In addition to identifying the most cost-effective form of treatment, review programs can serve to uncover fraudulent claims seeking payment for treatment that was not performed.[31] Indeed, the very existence of such programs and the knowledge that claims will be scrutinized serves as an effective deterrent in discouraging such schemes.[32]

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[30] As the Commission found, such options were "prohibitively expensive" to be considered adequate substitutes. (Pet. App. 87a-88a). Such increases in cost resulting from the administration of the health insurance program would, of course, be reflected in increased premiums.

[31] The cost savings achieved by uncovering fraud can be significant. Since 1977, Blue Cross and Blue Shield of New York has recovered more than $9 million in fraudulent payments. Blue Cross and Blue Shield of Michigan has saved $10.1 million through its fraud unit. *Blue Cross/Blue Shield Uses Fraud Squads to Curb Insurance Abuse*, Employee Benefit Plan Rev. 54-55 (July 1983). Although the record here expressly does not contain any findings regarding fraudulent claims (*see* Pet. App. 140a), the effect of the group boycott on efforts to uncover fraud must be taken into account when analyzing the anticompetitive effect.

[32] Review of medical treatment has been recognized as contributing to a reduction in the number of marginal or unnecessary procedures performed. This phenomenon, known as the "sentinel effect", reflects the fact that a physician may not recommend a marginal procedure if he knows the recommendation will be re-

2. *The Boycott Affected Competition Among Dentists With Respect to the Policy of Submitting X-Rays to Insurers.*

By orchestrating a collective refusal to provide x-rays, the boycott reduced or eliminated competition among dentists with respect to their dealings with insurers. Because of the boycott, patients covered by third-party health plans "found it difficult to purchase care from dentists who would satisfy the terms of their coverage." (Pet. App. 85a). This result was different from what would have occurred, in the absence of the collective agreement, in a market characterized by free and open competition among dentists.

The refusal to provide x-rays also had a direct effect on the efforts of insurers and other third-party payers to implement cost containment measures. (*Id.* at 86a). Although the Commission described conclusions about harm to competition in the dental insurance market as "unnecessary" to its decision, it recognized:

> [R]espondent's efforts to achieve a uniform course of conduct among dentists in their dealings with dental insurers affected a significant aspect of the insurers' businesses, i.e., the operation of cost containment efforts through the "alternative benefits" mechanism. The harm to these efforts may have reduced competition among insurers by preventing them from competing on the basis of reduced premiums. Respondent's activities may also have prevented new entrants from obtaining customers by offering innovative and effective cost-containment measures.

(*Id.* at 87a).

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viewed. *See* Friedman, *Second-Opinion Programs Come Into Their Own*, 58 Hospitals 105, 108 (1984). One study has ascribed 10 to 24 percent of the reductions in insurance claims under review programs to this effect. *Id.* Review programs, of course, have a similar deterrent effect on fraudulent claims.

In the end, of course, the additional costs resulting from the group boycott were passed on to the purchasers of dental services and spread throughout society as a whole in the form of higher prices for goods and services.[33] These factors, which were dismissed or ignored by the court of appeals, amply demonstrate the anticompetitive effect necessary to establish a violation of Section 5.

D. No Procompetitive Effects Have Been Demonstrated As a Result of the Collective Refusal to Provide X-Rays.

In contrast to the clear evidence of economic motive and anticompetitive effect, the court of appeals failed to identify and, indeed, the record is silent concerning any procompetitive results associated with the collective refusal to provide x-rays. There is no indication that the cost containment efforts requiring access to dental x-rays had any adverse effects on patient health or the quality of care received. Nor is there any evidence that the refusal to provide x-rays served a legitimate, procompetitive purpose. For example, as the Commission found:

> There is no basis for concluding that IFD's concerted refusal to deal encouraged development of new methods of care delivery or otherwise encouraged competition among individual dentists.

(Pet. App. 96a).

This fact is critical, for IFD has not and cannot offer any plausible argument that its group boycott would, under any scenario, promote competition by encouraging lower prices or higher output.[34] As discussed above, such

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[33] As the Commission noted, "The final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs." (Pet. App. 86a).

[34] The record similarly does not contain any evidence that the group boycott had procompetitive effects by injecting new forms of competition, reducing entry barriers, or facilitating broader consumer choice.

a showing is an essential element of any defense under the Rule of Reason. As this Court has recognized:

> Contrary to its name, the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions.

Professional Engineers, supra, 435 U.S. at 688.[35] In the absence of such showing of any procompetitive benefits, and given the evidence of economic motive, the mere invocation of "legal, moral, and ethical" considerations relating to quality dental care is clearly insufficient to satisfy the balancing test of the Rule of Reason.

If affirmed, the Seventh Circuit's opinion would frustrate cost containment efforts and diminish the welfare of consumers who would have to pay higher prices for health care services and insurance coverage. It would have a far-reaching and even more costly future effect, however, by sanctioning a talismanic formula of "legal, moral, and ethical" considerations to justify anticompetitive action by professionals. Such a result would be contrary to this Court's precedents and the national interest. The Seventh Circuit's decision should be reversed and the Commission's opinion and order reinstated.

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[35] Thus, in rejecting the asserted public health and safety arguments advanced to support a ban on competitive bidding, this Court in *Professional Engineers* concluded that "the Rule of Reason does not support a defense based on the assumption that competition itself is unreasonable." 435 U.S. at 696. *See also Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (rejecting attempt to justify price-fixing on ethical grounds).

CONCLUSION

The opinion and judgment of the court of appeals should be vacated and the case remanded with instructions to affirm and enforce the order of the Commission.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

Supreme Court, U.S.
FILED
DEC 6 1985
JOSEPH F. SPANIOL, JR.
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No. 84-1809

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1985

FEDERAL TRADE COMMISSION,
Petitioner,

v.

INDIANA FEDERATION OF DENTISTS
Respondent.

OR WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR AMICUS CURIAE WASHINGTON BUSINESS GROUP ON HEALTH IN SUPPORT OF PETITIONER

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December 6, 1985

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BRIEF FOR AMICUS CURIAE WASHINGTON BUSINESS GROUP ON HEALTH IN SUPPORT OF PETITIONER

The Washington Business Group on Health ("WBGH") submits this brief amicus curiae in support of Petitioner Federal Trade Commission ("Commission") and in

opposition to Respondent Indiana Federation of Dentists ("IFD"). It is accompanied by written consents from Petitioner and Respondent.

INTEREST OF AMICUS CURIAE

The Washington Business Group on Health ("WBGH") is a nonprofit organization of more than 150 of the nation's largest corporate employers. (A list of the WBGH members is set forth in the Appendix attached hereto.) It is the only national organization created for and solely devoted to the health policy and responsible cost management interests of major employers.

The WBGH member companies are well aware of the staggering cost of health

care insurance. Each year, WBGH member companies provide medical insurance protection, including, in many cases, dental insurance, to between 35 and 45 million people at an average annual cost for a single family policy of nearly $2,000.

From 1977 to 1981, WBGH member companies typically experienced annual premium increases of 20 to 40 percent. Today, the rate has dropped to increases of 5 to 15 percent. This dramatic reduction in premium increases is the result of private companies joining with the federal and state governments, labor unions and consumers to control health care costs. WBGH believes that such cost management is necessary to fulfill our national goal of providing all Americans

access to needed medical care. Accordingly, WBGH has a direct interest in any decision of this Court concerning the application of the antitrust laws to concerted efforts by health care providers to thwart health care cost management measures.

SUMMARY OF ARGUMENT

This case raises the issue of whether a group of health care providers can collectively refuse to provide the purchaser of their services the information upon which quality, appropriateness and price for their services can reasonably be determined. Specifically, the issue presented is whether a concerted refusal by a group of dentists to provide information to the

insurers who pay for the dental services provided on behalf of their policyholders is permissible under the antitrust laws based solely on the dentists' determination of their own moral and ethical responsibilities.

The court of appeals' de facto exception from the antitrust laws for group boycotts by professionals which purportedly promote "legal, moral and ethical" policies violates established legal precedent and threatens to undermine health management efforts nationwide. By authorizing health care providers to frustrate experienced and successful health management programs, which are designed to control costs as well as enable buyers of health care to make

informed purchasing decisions, the court of appeals' decision threatens to hurt the very persons the antitrust laws were designed to protect -- consumers. Consumers everywhere need protection from those who would subvert the principles of a free market for their own economic interest; health care providers who are so inclined do not warrant protection from normal restraints on anticompetitive behavior.

Moreover, the court of appeals' implicit acceptance of the IFD's justification for its concerted refusal to provide requested information to insurers frustrates the goals of the antitrust laws by permitting group boycotts to undercut

specific cost management terms in contracts negotiated by employers on behalf of their employees. The court's ruling thus conflicts with a fundamental goal of the antitrust laws: to protect free market competition in which parties are free to negotiate and benefit from the terms of their bargain.

ARGUMENT

I. THE COURT OF APPEALS IMPROPERLY CREATED A DE FACTO EXCEPTION FROM THE ANTITRUST LAWS FOR GROUP BOYCOTTS BY PROFESSIONALS WHICH PURPORTEDLY FURTHER "LEGAL, MORAL AND ETHICAL" POLICIES IN PROVIDING "QUALITY DENTAL CARE"

The United States Court of Appeals for the Seventh Circuit's majority decision threatens to open the door for health care professionals of all types to evade

antitrust scrutiny simply by invoking ethical policies which supposedly promote "quality" health care. Such an unsupported and noncompetitive deviation from the fundamental tenets of antitrust analysis cannot stand.

This Court has long recognized that, in examining an agreement in restraint of trade, such as a group boycott, the critical inquiry under the antitrust laws is whether the agreement furthers competition or frustrates competition. National Society of Professional Engineers v. United States, 435 U.S. 679, 691-92 (1978). This analysis applies with equal force in the health care industry. Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 104 S. Ct. 1551, 1565-66 n.42

(1984); see Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). Moreover, the decisions of this Court clearly establish that members of the learned professions and their professional associations cannot hide behind a cloak of "professionalism," "ethics" or "public health or safety" from the reach of the antitrust laws. E.g., Professional Engineers, 435 U.S. 679 (ethical canon prohibiting competitive bidding purportedly to prevent inferior work); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975) (public service purportedly justified price fixing); American Medical Association v. United States, 130 F.2d 233, 247 (2d Cir. 1942), aff'd, 317 U.S.

519 (1943) (group boycott of health plan on purported health grounds).

Contrary to these well-settled antitrust principles, the court of appeals implied throughout the majority opinion that since the IFD's concerted refusal to submit x-rays to insurers stemmed from a "legal, moral, and ethical" policy to promote "quality health care," the conduct was justified. See Indiana Federation of Dentists v. Federal Trade Commission, 745 F.2d 1124, 1135-36, 1138-44 (7th Cir. 1984). In so ruling, the court completely ignored this Court's teaching in Professional Engineers that such ethical norms are only relevant under an antitrust analysis to the extent they promote competition. 435 U.S. at 696. See also

Smith v. Pro Football, Inc., 593 F.2d 1173, 1188-89 (D.C. Cir. 1978) (concerted action "can survive scrutiny under the rule of reason only if it is demonstrated to have positive, economically procompetitive benefits that offset its anticompetitive effects" (emphasis in original)). Because the court of appeals cites no evidence that the economically motivated concerted refusal to submit requested x-rays in fact promoted competition among dentists, any "legal, moral and ethical" considerations cannot offset what the Commission found to be clearly anticompetitive effects. Simply because the majority of the court believed the dentists' boycott should be exempt from the antitrust laws is not enough. As

observed by this Court, "'restraints of trade within the purview of the [anti-trust] statute[s]. . .[can]not be taken out of that category by indulging in general reasoning as to the expediency or the wisdom or want of wisdom of the statute which prohibited their being made.'" Professional Engineers, 435 U.S. at 690 (quoting Standard Oil Co. v. United States, 221 U.S. 1, 65 (1911)).

Furthermore, the Seventh Circuit's majority opinion cites absolutely no evidence that submitting x-rays to insurers for utilization review conflicts with any "legal, moral or ethical" standard for providing quality dental care. As to a purported "legal" justification for the group boycott, the IFD argued that

insurers' use of unlicensed lay personnel to review claims for the purposes of benefit determinations constitutes the unlawful practice of dentistry, and that dentists who submit dental x-rays aid and unbet the unlicensed practice of denistry in violation of Indiana law. Indiana Federation of Dentists, 745 F.2d at 1127. The administrative law judge ("ALJ") and the Commission both found, however, that Indiana law did not prohibit unlicensed employees from simply reviewing claims to approve paying benefits, and the court of appeals did not disturb this finding. Id. at 1132-34. Indeed, the ALJ found that even if the unlicensed personnel were engaged in the unlawful practice of dentistry, Indiana law does not authorize

dentists "to organize a group boycott to help enforce the law." In re: Indiana Federation of Dentists, 101 F.T.C. 57, 137 (1983).

Equally lacking is any evidence that reviewing x-rays violates any "moral or ethical" standard of care. The majority opinion incorrectly assumed that insurers' review of x-rays in processing insurance claims conflicts with "legal, ethical and moral standards of quality care. . .[by] formulat[ing] a course of dental treatment . . .based solely upon an insurance claim and copies of a patient's dental x-rays." Indiana Federation of Dentists, 745 F.2d at 1138. In fact, the insurers in this case did not "formulate a course of treatment;" they simply determined how much

they would pay for treatment. Utilization review in no way interferes with the dentist's treatment decision. Moreover, the court of appeals cites no evidence to suggest that review by insurers results in substandard dental care. In fact, as will be discussed in the next section, utilization review performs an important role in protecting patients from unnecessary and inappropriate medical treatment.

II. THE COURT OF APPEALS' DECISION FRUSTRATES EMPLOYERS' EFFORTS TO ACHIEVE HEALTH COST MANAGENMENT BY OBTAINING RELEVANT INFORMATION FROM PROFESSIONALS

As representatives of corporate employers involved in efforts to curtail health care costs, the WBGH is concerned

that the court of appeals' justification for anticompetitive conduct under the guise of adherence to "legal, moral and ethical" responsibilities would seriously undermine responsible cost management efforts nationwide.

Employers and other purchasers of health care have traditionally lacked the types of information which would enable them to buy medical care with the same degree of prudence that would be even minimally required for the purchase of equipment, buildings or the hiring of new employees. Until recently, neither cost nor quality of medical care were central to the purchasing process. These factors were not monitored by the buyer. The

seller, on the other hand, had every economic incentive to let costs escalate, and did not face any of the normal, business demands for quality or economic accountability. Further, patients were not affected by traditional market forces since their employer-provided insurance often obviated any need for prudent purchasing. In addition, patients frequently lacked information upon which to make comparative quality determinations.

The increasing cost of health care expenditures[1/] has led employers, health

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1/ In 1983, the United States spent approximately $355 billion on health care. See Gibson, Levit, Lazenby & Waldo, National Health Expenditures, 1983, 6 Health Care Fin. Rev. 1 (Winter, 1984).

insurance companies and consumers to adopt cost management measures.[2/] These efforts include preadmission certification, profile analysis, concurrent review, case management, second surgical opinion and "flexible spending accounts" (pre-tax accounts available to employees for certain health care services).[3/]

2/ See, e.g., Council on Wage and Price Stability, Employee Health Care Benefits, Labor and Management Sponsored Innovations in Controlling Cost, 41 Fed. Reg. 40928 (Sept. 17, 1976).

3/ See, e.g., F. Lee, Business and Hospitals (1985) (unpublished manuscript to be published Fall, 1986 by Aspen Publications) [hereinafter cited as "Lee"]; Havighurst, Professional Restraints on Innovation In Health Care Financing, 1978 Duke L.J. 303, 321-25 (1978) [hereinafter cited as "Havighurst"].

Precertification programs, such as those involved in this case, are the fastest growing strategy employed by corporations to manage medical costs and avoid unnecessary medical treatment while preserving quality care.[4/] Each of these cost-management techniques is designed to promote more informed purchasing of health care.

Cost-management efforts adopted by employers, including several WBGH member

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4/ A 1984 Wyatt Company survey indicated that 14 percent of 269 companies surveyed require pre-certification and 59 percent of those companies require mandatory second opinions for some surgical procedures. The Wyatt Company, Group Benefits Survey, 1984 (1984).

companies, have significantly reduced health care costs and inappropriate and clinically unjustified treatment while preserving quality care. For example:

- a utilization review program adopted by the Deere & Co. drastically cut hospital days by 31.2 percent in Iowa and by 35.6 percent in Illinois; a similar program used by Caterpillar Tractor achieved a 18.4 percent reduction in hospital days;5/
- a flexible spending account (FSA) established by Quaker Oats as part of its Health Incentives program led in 1984 to a 20 percent reduction in

5/ P. Fox, W. Goldbeck & J. Spies, Health Care Cost Management 75 (1984).

inpatient care. Xerox Corporation reported similar reductions in utilization after adopting its FSA.6/

- prepayment review of dental claims by U.S. Administrators achieved a 10 percent savings for the firm's clients;7/
- a pre-certification program utilized by the Chrysler Corporation revealed that 155 out of 222 patients were inappropriate inpatient admissions for back treatment, yielding a total of 2,264 unnecessary days

6/ Lee at 19.

7/ Interview with Dr. Donald Mayes, Vice President of Dental Affairs for U.S. Administrators (Nov. 25, 1985).

in Detroit-area hospitals;[8] and

- pre-admission review programs saved Zenith nearly a quarter of a million dollars in 1983, and saved General Motors 3.8 million dollars in 1984 on podiatry services alone.[9]

Clearly such programs play a central role in controlling health care costs and monitoring the appropriateness of medical care.

Utilization review programs are particularly appropriate for evaluating

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8/ Rosenbaum, Chrysler Program Saves Millions in Health Costs, N.Y. Times, Apr. 29, 1985, at B6, col. 3.

9/ Lee at 28.

payment under group dental health care plans. Dentistry is a treatment-oriented practice, overwhelmingly apportioned to solo practitioners. These professionals typically lack the checks and balances and access to colleagues for peer review that exist for other medical specialities. Moreover, dentistry is a $15 billion a year industry which requires cost and quality monitoring to ensure efficacy and efficiency for our nation's dental patients.

The cost management strategies described above obviously depend on insurer access to accurate utilization data and other medical information, such as x-rays. Yet the denial of access to

x-rays will not stop review, claims controls, or retrospective denial of payment. Rather, failure to supply such information will result in lower quality review, less effective pre-care interventions to enhance quality and individuality of care, less cooperation between buyers and sellers and less honest communication between dentist and patient.

The IFD nonetheless asserts that cost management measures involving insurers' claims review of x-rays violate established standards of quality dental care. The IFD essentially contends that review cannot be legitimately conducted absent a "complete examination" of the patient. Indiana Federation of Dentists, 745 F.2d

at 1129-30. This view is expressly contradicted by evidence of more than ten years of claims review without patient examination. Moreover, such a requirement would be administratively absurd, fiscally irresponsible, unnecessarily intrusive for patients, and totally contrary to the IFD's expressed desire that review not interfere in the patient-dentist relationship.10/

In sum, the IFD's argument that restricting the insurer's and patient's

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10/ See Indiana Federation of Dentists, 101 F.T.C. at 84 (unchallenged testimony that it is not economically feasible and would be a waste of time for insurers' consultants to visit dentists to review x-rays).

access to information, such as that contained in x-rays, is necessary to ensure quality care could not be further from the truth. The cost-management efforts of employers involving review of literally hundreds of thousands of cases have clearly resulted in higher quality care. Patients are protected from all types of unnecessary and dangerous treatment, and are given the opportunity to make informed choices about health care. There is simply no relationship between the provision of x-rays for review and the ability of dentists to provide high quality care. In fact, if the care provided by the members of the IFD is of high quality, they have absolutely no reason to fear review.

III. THE PROCOMPETITIVE GOAL OF THE ANTITRUST LAWS FAVORS ENFORCING COST MANAGEMENT MEASURES NEGOTIATED BY EMPLOYERS AND INSURERS

Antitrust law is designed to promote competitive markets in which buyers and sellers are free to bargain for the best price and optimal type of good or service. See Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922, 925 (1st Cir. 1984), cert. denied, 105 S. Ct. 2040 (1985).

In the health insurance context, the insurance company is the buyer, purchasing physicians' services for the account of another, the insured. As in any buyer-seller relationship, the buyer is entitled to negotiate the best price for given services, and is entitled to receive exactly

what is bargained for. As explained by Judge Breyer of the First Circuit:

> Suppose a father buys toys for his son -- toys the son picks out. Or suppose a landlord hires a painter to paint his tenant's apartment, to the tenant's specifications. Is it obviously lawful for the father (the landlord) to make clear to the seller that the father (the landlord) is in charge and will pay the bill? Why can he not then forbid the seller to charge the child (the tenant) anything over and above what the father (the landlord) pays -- at least if the seller wants the buyer's business?

Kartell, 749 F.2d at 925.

Under this rationale, courts have uniformly upheld contracts between

insurers and health care providers in which insurers have negotiated particular cost-management terms on behalf of their group health care plans in return for direct payment by the insurer. See, e.g., Kartell, 749 F.2d 922 (ban on balance billing by physicians); Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross and Blue Shield of Connecticut, Inc., 675 F.2d 502 (2d Cir. 1982) (ban on balance billing by participating pharmacies); Qualified Auto Body, Inc. v. Allstate Insurance, 660 F.2d 1195 (7th Cir. 1981), cert. denied, 455 U.S. 1020 (1982) (direct reimbursement to auto repair shops); Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80 (3d Cir.) cert. denied, 414 U.S. 1093 (1973)

(discounts to large purchaser of hospital costs); Pennsylvania Dental Association v. Medical Service Association of Pennsylvania, 574 F. Supp. 457 (M.D. Pa. 1983), aff'd, 722 F.2d 733 (3d Cir. 1984) cert. denied, 105 S.Ct. 2021 (1985) (ban on balance billing for dental services); Davidowitz v. San Diego County Dental Society, 1983-1 Trade Cas. (CCH) ¶ 65,231 (S.D. Cal. 1983).

For similar reasons, employees covered by group dental insurance plans are entitled to benefit from cost-management measures instituted on their behalf by dental insurers. In this case, employers and labor unions, representing employees, were sufficiently concerned about the escalating cost of insurance

premiums to negotiate for cost-management procedures in their group dental policies. Due to the IFD's group boycott, however, the employee/patients covered by dental plans were deprived of the benefit of such cost-management efforts, primarily because the dentists viewed such efforts as a direct threat to their revenues.11/ In the words of the

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11/ The record clearly establishes that the group boycott was economically motivated. In a speech to IFD's Council on Dental Care Programs, Dr. McClure, President of the IFD, declared:

> We are fighting an economic war where the very survival of our profession is at stake. . . .The name of the game is money.

(Footnote continued on next page)

Commission, "The final victim in this distortion of the market was the patient policyholder who lost the value of his insurance company's efforts to contain costs." Indiana Federation of Dentists, 101 F.T.C. at 173.

The IFD's concerted refusal to furnish x-rays to insurers thus thwarted legitimate, cost-management efforts negotiated by employers and insurers. As

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(Footnote continued from previous page)
Indiana Federation of Dentists, 101 F.T.C. at 170. Later, Dr. McClure explained that "'the fight for x-rays will continue... . This is the only way they can control their costs.'" Id. As observed by the ALJ, "[t]he economic interest of dentists in not being 'second-guessed' by their patients' insurers is too plain to need elaboration." Id. at 72.

observed by Professor Havighurst, such group boycotts perpetuate physicians' (and dentists') substantial monopoly power over their patients at the expense of the patient/consumers:

> [c]oercive refusals to deal . . .have been used to perpetuate those market conditions that underlie the individual doctor's market power and to frustrate both the efforts of consumers to combine for increased bargaining effectiveness and attempts by financing intermediaries to help consumers overcome their purchasing disadvantages.

Havighurst at 344. This blatant restraint on competition at the expense of consumers cannot pass antitrust scrutiny.

CONCLUSION

For the reasons set forth herein, the decision of the court below should be reversed.

Respectfully submitted,

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1985

No. 84-1809

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Petitioner,

v.

INDIANA FEDERATION OF DENTISTS,

Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Seventh Circuit

APPENDIX TO BRIEF FOR AMICUS CURIAE WASHINGTON BUSINESS GROUP ON HEALTH IN SUPPORT OF PETITIONER

The following are members of the Washington Business Group on Health:

AMAX
AMF
ARA Services
ASARCO
AT&T
Aetna Life & Casualty
Air Products & Chemicals
Allied Corporation
Aluminum Co. of America
American Can
American Cyanamid
American Express
American Home Products
American Medical International
American Natural Resources Company
American Standard
American Stores Company
Armco, Incorporated
Armstrong World Industries
Atlantic Richfield

Bank of America
Bankers Trust
Beatrice Foods
Bechtel Power Corp.
Bethlehem Steel
Bell Comm. Research
Boeing
Boise Cascade
Bristol-Myers
Buck Consulting Actuaries
Burlington Industries
Burlington Northern

CIGNA
CPC International
Campbell Soup
Carter Hawley Hale
Caterpillar Tractor
Champion International
Chase Manhattan
Chemical Bank
CHEVRON
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Control Data Corp.
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Dana Corporation
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Dexter Corporation
Digital Equipment
Dresser

EDS Federal
E. I. duPont de Nemours
Eastman Kodak
Eckerd, Jack Corporation
Eli Lilly
Equitable Life
Ernst & Whinney
Exxon

FMC
Federal Express
Federated Dept. Stores
Firestone Tire & Rubber
Ford Motor

GATX Corporation
GTE Service Corporation
General Electric
General Foods
General Mills
General Motors
General Signal
General Tire & Rubber
Georgia-Pacific
Goodrich Company, B.F.
Goodyear Tire & Rubber
Grace, W. R.

Heinz, USA
Hewlett-Packard
Hoffmann-LaRoche
Honeywell
Hospital Corporation of America

IBM Corporation
IC Industries
Inland Steel Company
International Harvester

Jewel Companies
John Hancock
Johnson & Johnson
Johnson & Higgins

Kaiser
Kimberly-Clark
Kroger Company

LTV
Lincoln National Life

3M Corporation
Macy, R. H.
Manufacturers Hanover Trust
Marriott Corporation
Massachusetts Mutual Life
Mead Corporation

Mercer, William M. & Co.
Merck
Merrill-Lynch
Metropolitan Life
Milliken & Company
Mobil Oil
Monsanto
Morgan Guaranty Trust
Motorola

National Chain Drug Stores
National Medical Enterprises
Northern Telecom
Norton Company

Olin
Owens-Corning Fiberglas
Owens-Illinois

PACCAR
PPG
PHH Group
Pacific Telesis
Penney, JC
Pfixer
Philip Morris
Pioneer Hi-Bred Intern'l
Pitney Bowes
Plantronics, Inc.

Polaroid Corporation
Procter & Gamble
Provident Life
Prudential

Quaker Oats

RCA
Ralston Purina
Reynolds Metal
Rockwell International
Rohm & Haas

SCM
Sandoz, Incorporated
Sears, Roebuck & Co.
Shell Oil
Southern California Edison
Southern New England Telephone
Southland Corporation

Sperry Corporation
Staley, A. E., Manufacturing
Standard Oil of Indiana
Standard Oil Company of Ohio
Stanley Works
Stauffer Chemical
Stouffer Corporation
Sun Company
Sundstrand Chemical

TRW
Tenneco
Texas Eastern
Texas Gas Transmission
Transamerica Occidental
Travelers

Union Camp
Union Carbide
Union Oil of California
Union Pacific
U.S. Steel
United Technologies

Valley National Bank

Wang Laboratories
Warner Lambert
Western Union
Westinghouse
Weyerhaeuser
Whirlpool
Woodward, Ryan, Sharp & Davis
Wyatt Company

Xerox

AMICUS CURIAE

BRIEF

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Supreme Court of the United States

OCTOBER TERM, 1985

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vs.

INDIANA FEDERATION OF DENTISTS,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF *AMICUS CURIAE* OF AMERICAN ASSOCIATION OF RETIRED PERSONS IN SUPPORT OF PETITIONER

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BRIEF AMICUS CURIAE OF AMERICAN ASSOCIATION OF RETIRED PERSONS IN SUPPORT OF PETITIONER

Statement of Interest of the Amicus Curiae

The American Association of Retired

Persons ("AARP"), of 1909 K Street, N.W., Washington, D.C. 20049, is a not-for-profit membership corporation of more than 20 million persons over the age of 50. AARP is the largest organized group of older Americans in the country. In representing the interests of its members, AARP seeks to: (a) enhance the quality of life for older persons; (b) promote independence, dignity and purpose for older persons; (c) lead in determining the role and place of older persons in society; (d) sponsor research on physical, psychological, social, economic and other aspects of aging; and (e) represent the point of view of older persons as consumers of goods and services.

In the area of health care, AARP's overriding interest is to foster and promote efficient delivery to older persons of the widest range and highest quality

services at the lowest attainable cost, and to assure the broad availability of those services to persons living within fixed or limited incomes. To achieve that goal, AARP is conducting a nationwide health care cost containment campaign whose premise is "keep the care, cut the cost." Many millions of AARP's members are insured under health insurance plans which provide payments for dental and medical treatment.

The decision below will significantly retard the legitimate efforts of such health care insurers to contain the costs of treatments covered by their plans. In consequence, the cost of such insurance (which will be borne by AARP's members either directly or indirectly) will necessarily increase, and the scope or extent of the benefits provided by such plans is likely to be reduced. Because either result would constitute a severe

blow to the interests of AARP's members who depend upon such insurance plans to safeguard their health, AARP has sought leave to submit this brief in support of the petition for reversal of the lower court's judgment. (The consent of the parties has been granted; see Exhibits A and B.)

ARGUMENT

I. THE COURT OF APPEALS COMMITTED ERRORS OF LAW WHICH REQUIRE REVERSAL OF THE JUDGMENT BELOW

With respect to the compelling legal reasons why the judgment of the Court of Appeals should be reversed and the case remanded with instructions that the opinion and order of the Federal Trade Commission be affirmed, AARP endorses and adopts the arguments set forth in the brief of the Federal Trade Commission.

II. THE PUBLIC POLICY WHICH FAVORS CONTAINMENT OF THE COST OF DENTAL AND MEDICAL HEALTH SERVICES AND INSURANCE REQUIRES REVERSAL OF THE JUDGMENT BELOW

The containment of the already high and rapidly growing cost of dental and medical health care services and the insurance premiums which reflect those costs, and, in addition, the maintenance or expansion of current levels of benefits provided by health care insurance plans, are of critical importance to older Americans. Many millions of older Americans who are active members of the nation's workforce or retired persons are consumers of health care insurance. Increases in premium rates which result from the failure of insurers to contain the cost of health care services can have a significant impact upon the financial security of persons who must live on fixed or limited incomes, or whose insurance premiums are paid in whole or part

by their employers in lieu of higher direct compensation or other fringe benefits.

Moreover, since increases in the cost of health care services can lead to curtailment of coverage for such services, barriers against cost containment such as those erected by the dental care providers here can have a devastating effect upon the physical well-being of persons who depend upon health care insurance to defray a substantial portion of their health care expenses.

Since older Americans typically require more extensive health care services than others to maintain their continued health, the impact of the blow dealt by the Court of Appeals' judgment to programs seeking to contain rising health care costs will fall with particular harshness upon older consumers of those services.

Viewed from this social perspective, the importance of vindicating the public policy in favor of containment of health care costs is compelling. This is especially so on the factual record presented on this appeal. As the Federal Trade Commission's brief demonstrates, the cost containment strategy which the dentists' collective conduct opposed was not capable of causing any reduction in the quality of dental care rendered by those providers. Especially where the quality of care is not at risk, collective action intended to defeat the containment of the cost of treatment should be subjected to the most stringent scrutiny.[1] Where,

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1. Expenditures for dental services rose by 15% in 1984 as compared with a 9% increase in total health costs for that year. "National Health Expenditures, 1984", HHS News, U.S. Dept. of Health and Human Services (July 31, 1985), Table 3; Gibson, Robert M., et

(continued on next page)

as here, the collective conduct also serves to prevent competition among health care providers by deterring voluntary compliance with insurers' cost containment programs, such conduct should not be sanctioned.

(continued)

al. "National Health Expenditures, 1983", Health Care Financing Review (Winter 1984), p. 8. Under such circumstances, an x-ray review, which is the functional equivalent of a "second opinion", is a legitimate means of avoiding unnecessary or excessive dental procedures which increase costs without tangible benefit to the patient.

CONCLUSION

The judgment of the Court of Appeals should be reversed and the case remanded with instructions that the Court affirm and enforce the order of the Federal Trade Commission.

Dated: New York, New York
December 6, 1985

Respectfully submitted,

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Exhibit A

No. 84-1809

FEDERAL TRADE COMMISSION,

Petitioner,

v.

INDIANA FEDERATION OF DENTISTS,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals
For the Seventh Circuit

CONSENT

On behalf of the Federal Trade Commission, the undersigned hereby consents, pursuant to Rule 36 of the Rules of the Supreme Court, to the filing of a brief amicus curiae on behalf of the American Association of Retired Persons.

/s/Ernest J. Isenstadt
ERNEST J. ISENSTADT
Assistant General Cousel
Federal Trade Commission

Dated: December 4, 1985

Exhibit B

December 4, 1985

Bruce W. Graham, Esq.
P.O. Box 779
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Re: FTC v. Indiana Federation of Dentists -- No. 84-1809

Dear Mr. Graham:

This will confirm our telephone conversation of today in which you consented, on behalf of Respondent, to the filing of an Amicus Brief by the American Association of Retired Persons in support of Petitioner in the above referenced matter.

Very truly yours,

/s/Peter N. Greenwald

Peter N. Greenwald

PNG:tr

AMICUS CURIAE

BRIEF

Supreme Court, U.S.
FILED
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JOSEPH F. SPANIOL, JR.
CLERK

No. 84-1809

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

FEDERAL TRADE COMMISSION,
Petitioner

v.

INDIANA FEDERATION OF DENTISTS,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether the court of appeals correctly held that the Federal Trade Commission ("FTC") failed to make the findings of fact on market definition, market power and anticompetitive effects required by the traditional rule of reason analysis which the FTC employed in the administrative proceedings to analyze respondent's activities.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

No. 84-1809

FEDERAL TRADE COMMISSION,
Petitioner

v.

INDIANA FEDERATION OF DENTISTS,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

---

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

The American Medical Association ("AMA") is a private, voluntary, nonprofit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and the improvement of public health. Its membership exceeds 280,000 physicians and medical students.

The AMA is dedicated to promoting the public welfare through the maintenance of high professional standards and the provision of quality health care. In pursuit of these goals, the AMA and its members participate in a wide range of accreditation, certification and peer review programs designed to enhance the quality of medical care for patients.

Because of the breadth of the Sherman Act, activities of the AMA and its members, which have the purpose and effect of enhancing quality in the practice of medi-

cine, may nonetheless be challenged as anticompetitive by anyone who is adversely affected by such activities. Accordingly, the AMA and its members have a direct interest in any case that may affect how the antitrust laws are applied to joint efforts to enhance the quality of medical practice and promote appropriate patient care.

The FTC in this case has challenged the practice of respondent, a small group of dentists in Indiana, not to submit x-rays to third party insurers that would be used in deciding how much to pay for dental work for an insured patient. The asserted reason for respondent's rule is the dentists' view that treatment decisions cannot be made on the basis of x-rays alone and that any decision by the insurer regarding a proposed or completed treatment could adversely affect the dentist-patient relationship. The court of appeals held that the FTC had failed to make findings required by a traditional rule of reason analysis to demonstrate how the dentists' conduct violated the antitrust laws.

As a matter of policy, the AMA encourages physicians to cooperate on an individual basis with third party insurers in order to assist patients in securing the full benefits of their insurance and to aid insurers in containing costs. This case is of concern to the AMA, not because of respondent's particular practices but because the Court, in deciding the factual issue presented by the FTC, may address legal issues which generally affect professional self-regulation. Although no broad or novel legal issues are properly presented in this case, any decision or statement by this Court concerning the antitrust standards which apply to professional self-regulation can have potentially dramatic effects on efforts of the medical profession to promote quality health care.

The AMA therefore wishes to present its views and to urge this Court to decide the instant case solely upon the factual issue actually presented and not to make new law in this area which may adversely affect the relationship between the antitrust laws in a way that will unduly impede efforts of professionals to regulate themselves in the public interest. Resolving the tension between the antitrust laws and organized professional activities is and will continue to be an important task for this Court, but this case is an inappropriate vehicle for doing so.[1]

STATEMENT

1. During the 1970's, third party dental insurance plans enjoyed "phenomenal growth" in this country due primarily to the inclusion of such plans in collective bargaining agreements between unions and employers. Pet. App. 138a-139a. To make these plans profitable, insurers in recent years have undertaken various cost containment measures. Two such measures of importance to this case were 1) decisions by insurers to "predetermine claims," *i.e.*, to determine in advance which treatment proposed by a dentist the insurer would be willing to compensate, and 2) decisions by insurers after treatment by the dentist to reimburse only the "least expensive adequate course of treatment." *Id.* at 2a. In order to implement these measures, group dental health care insurers began requesting dentists to submit copies of their patient's x-rays with the patient's claim form. These documents would be reviewed initially by lay employees of the insurance company and, if the treatment plan or requested compensation was not approved, then the claim and x-rays would be submitted for review by a dentist selected by the insurer. *Id.* at 3a.

Respondent Indiana Federation of Dentists is an unincorporated association of dentists which in 1979 had 92 members who practiced primarily in three communities in Indiana. Pet. App. 142a, 144a. Respondent reacted to dental insurers' cost containment measures by

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[1] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

encouraging its members not to comply with insurers' requests for x-rays.[2] It claimed that "[p]roper diagnosis and treatment planning predicates the doctor correlating all diagnostic aids, with a history and with all clinical findings." *Id.* at 218a, 234a-235a. Respondent maintained that the insurers' review of treatment options based solely on x-rays, either before or after the treatment, would interfere with the dentist-patient relationship and would constitute the unauthorized practice of dentistry in violation of Indiana law.

2a. On October 18, 1978, the FTC filed a complaint against respondent[3] alleging that it was engaged in a restraint of trade in violation of Section 5 of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 45, because it had adopted a policy of discouraging its members from certain "dealings with third-party payers" which, *inter alia*, had the tendency to deprive customers of the benefit of cost containment measures by the insurers. 101 F.T.C. at 60.

The Administrative Law Judge ("ALJ") rendered an initial decision against respondent. Pet. App. 118a-283a. The ALJ found that respondent had engaged in a vigorous campaign to discourage its members from supplying

[2] The idea that dentists should not cooperate with third party insurers by providing x-rays was first advanced by the Indiana Dental Association ("IDA"), a statewide organization. In 1976, the IDA included in its "Principles for Determining the Acceptability of Plans for the Group Purchase of Dental Care" a provision precluding such plans from requiring the dentist to submit x-rays to a third party. Pet. App. 156a. The IDA, however, abandoned its concerted efforts with regard to third party insurers after this Court's decision in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975). In August, 1976, respondent was created and it continued to encourage its members not to cooperate with third party insurers who demanded x-rays to be reviewed by the insurers' employees. Pet. App. 143a-144a, 216a-219a.

[3] The IDA was mentioned in the FTC's complaint, but was not a named respondent.

insurers with x-rays. The ALJ acknowledged that respondent's actions did not affect any dentist competitors or affect any buyer-seller relationship and thus did not have the ordinary effects of a traditional boycott. Nevertheless, the ALJ held that respondent was engaged in a *per se* illegal boycott. *Id.* at 228a. Alternatively, the ALJ found that under a rule of reason analysis, which assumed without specific findings the existence of anticompetitive effects (*id.* at 229a-230a), there was no evidence that respondent's practices served any real health or quality of care interests that would justify any anticompetitive consequences of its concerted activity. *Id.* at 240a-241a.

b. On appeal from the ALJ's initial decision, the FTC held that respondent's practices violated Section 5 of the FTC Act. Pet. App. 54a-112a. Unlike the ALJ, the Commission concluded that respondent's x-ray rule was not *per se* illegal. Although it agreed that respondent's conduct constituted a "boycott," in some sense, the FTC pointed out that the conduct was aimed at "neither customers nor competitors" and that the conduct was not motivated solely by an anticompetitive animus (*id.* at 76a). Therefore, the FTC stated that the traditional rule of reason standard of antitrust review described by this Court in *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918), should be applied. Pet. App. 77a-78a.

The FTC did not, however, attempt to define the relevant geographic market or describe in any detail the nature of respondent's power in any market. Nor did it analyze whether respondent's policy had anticompetitive effects on other dentists or on dental patients. Instead, it analyzed the effects of respondent's practices on certain insurance companies, and concluded that "dentists were freed *to some extent*" from having to compete with respect to the provision of x-rays to insurers. *Id.* at 85a (emphasis added).

3. The court of appeals vacated the FTC's order. Pet. App. 1a-50a. The court held that respondent's conduct was not a "classic group boycott" because the concerted action clearly did not directly affect customers or competitors. *Id.* at 26a.[4] Accordingly, the court agreed with the FTC that it would be inappropriate to analyze respondent's conduct under a *per se* rule.

Like the FTC, the court concluded that respondent's conduct should be judged under the rule of reason standards of *Chicago Board of Trade*, which require "a showing of anticompetitive effect in the relevant market [as] an essential predicate of antitrust liability." Pet. App. 34a, quoting, *Phil Tolkan Datsun, Inc.* v. *Greater Milwaukee Datsun Dealers' Advertising Ass'n*, 672 F.2d 1280, 1287 (7th Cir. 1982). On this basic issue, the court held there were no findings by the FTC. The Court found that "[t]he record is void of any findings that dentists within these three areas [Anderson, Fort Wayne or Lafayette, Indiana] did, in fact, engage in any form of competition in their policy of dealing with insurers or in complying with the insurers' x-ray directive." Pet. App. 37a-38a. Thus, respondent's practices were not shown to have caused any significant anticompetitive effects. The court concluded that, although the FTC in the administrative proceeding had stated that it should apply the traditional rule of reason analysis under *Chicago Board of Trade*, it, in fact, had made findings adequate only for a "limited" or "truncated" rule of reason analysis, which were inadequate under the circumstances. (Pet. App. 41a).

Judge Fairchild concurred on a slightly different ground. He agreed with the majority that the FTC had

[4] The court explained that respondent's members did believe legitimately that "the dentist ' has a moral and legal responsibility to not allow a determination of his patient's condition to be made . . . without the benefit of a complete examination," instead of one based solely upon an x-ray. Pet. App. 22a-24a.

made no findings based on record evidence that respondent's practices had any significant anticompetitive effects. He wrote separately to emphasize that the majority's "repeated assertion that the concerted refusal resulted from a legal, moral and ethical policy of quality dental care" was unnecessary to vacate and remand because the FTC had failed to satisfy its threshold burden under a traditional rule of reason analysis of proving any substantial effect on competition. Pet. App. 49a.

SUMMARY OF ARGUMENT

I.

There is a significant tension between the goals of the antitrust laws to encourage competition in all markets including the provision of health care and the efforts of professionals and professional associations to promote quality health care by self-regulation. The scope of the Sherman Act and the complexity surrounding its standards create significant problems for legitimate self-regulatory efforts to promote quality health care. For these reasons, this Court has carefully avoided making any unnecessarily broad pronouncements in previous cases when professional activity has been challenged under the Sherman Act. See, *e.g.*, *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975). The Court should adhere to that practice here and decide only the narrow factual question presented.

II.

In the administrative proceeding, the FTC could have applied any of three basic legal standards under Section 1 of the Sherman Act to this case—a *per se* rule, a "truncated" or "limited" rule of reason or a full rule of reason analysis. The Commission expressly held that the *per se* rule was not appropriate because respondent's intent was not solely anticompetitive and the "boycott" did not affect any competing dentists or purchasers of dental services.

In contrast to other FTC cases, the Commission did not expressly hold that it was employing a limited rule of reason analysis, much less justify use of such an analysis to the admittedly novel practices of respondent. Instead, it expressly purported to apply the traditional, full rule of reason analysis described in *Chicago Board of Trade* v. *United States*, 246 U.S. 231 (1918).

Under the traditional rule of reason standard, the initial inquiry is always into the defendant's market power. The plaintiff has the burden of proving both that the defendant has market power and that the defendant's practice, in fact, adversely affected competition in that market. *Jefferson Parish Hospital Dist. No. 2* v. *Hyde*, 104 S.Ct. 1551 (1984). But the FTC failed to make adequate findings on these fundamental elements. Without any explanation, the FTC made no findings concerning the relevant market or respondent's power in that market. Nor did the FTC make findings that respondent's x-ray rule involved an element of competition among dentists or that anticompetitive effects resulted from that rule. It simply concluded that respondent's concerted action theoretically eliminated possible competition in the dentists' relationship with the insurers. The court of appeals therefore correctly vacated the FTC's order on narrow, factual grounds.

III.

In its brief in this Court, the FTC attempts, somewhat obliquely, to defend the Commission's administrative decision on the ground that an analysis of market power and anticompetitive effects was unnecessary because respondent's conduct could properly be analyzed under a "truncated" or "limited" rule of reason standard. The fatal flaw in this argument to this Court is that the Commission did not articulate this analysis in its administrative opinion. Therefore, its decision cannot be upheld by this Court on this ground because a reviewing court may only sanction an administrative agency's decision on the

grounds articulated by the agency itself. *Zuber* v. *Allen*, 396 U.S. 168 (1969).

Moreover, although the Court need not reach the issue, the FTC is incorrect that a limited rule of reason analysis would be appropriate in this case. This Court's decisions have dispensed with a detailed analysis of market, market power and anticompetitive effects only in *per se* cases and cases involving conduct which on its face directly restricts price or output. See, *e.g.*, *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978). Respondent's conduct on its face does not directly affect price or output. Accordingly, application of a "limited" or "truncated" rule of reason standard is inappropriate in this case which involves a complex area like third-party medical insurance with which courts have had limited experience.

ARGUMENT

I. THIS CASE IS NOT AN APPROPRIATE VEHICLE FOR MAKING NEW LAW WHICH ATTEMPTS TO RESOLVE THE TENSION BETWEEN THE ANTITRUST LAWS AND THE EFFORTS OF THE PROFESSIONS TO PROMOTE THE PUBLIC INTEREST THROUGH SELF-REGULATION

For over 30 years, this Court has recognized the difficulty of applying the prohibitions of the Sherman Act to professional activities. See *United States* v. *Oregon State Medical Society*, 343 U.S. 326, 336 (1952).[5] In more recent decisions, the Court has emphasized that the

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[5] In the *Oregon State Medical Society* case, 343 U.S. at 336, where the Court rejected an antitrust challenge to a professional society's refusal to deal with private health associations. Justice Jackson, speaking for the Court, observed "that there are ethical considerations where the historic direct relationship between patient and physican is involved which are quite different than the usual considerations prevailing in ordinary commercial matters." The Court thus strongly implied that special standards under the Sherman Act should apply to professional activities. *Ibid.* See *Semler* v. *Oregon State Board of Dental Examiners*, 294 U.S. 608, 612 (1935).

antitrust laws must take into account the legitimate and socially useful functions performed by the professions. As this Court observed in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975): "The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." See *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332, 349 (1982); *National Society of Professional Engineers* v. *United States*, 435 U.S. at 696. See also *NCAA* v. *Board of Regents*, 104 S.Ct. 2948, 2971 (1984).

These repeated statements reflect the Court's understanding of the tension between the potentially broad sweep of the antitrust laws and the value of organized professional activity to ensure quality of service to consumers. This tension makes it particularly important that the Court announce new legal principles affecting professional self-regulation only in cases in which the legal issues are sharply presented and thoroughly examined in all proceedings below. For reasons we discuss in parts II and III, this is not such a case.

In order to understand why it is vitally important for the Court to proceed with great care and not to make new law on an inadequate administrative record, it is necessary first to understand the two primary sources of the uneasy relationship between the antitrust laws and professional self-regulation—varying antitrust standards and evolving rules about when and how these standards apply to organized professional activities.

A. This Court Has Applied Differing Levels Of Judicial Scrutiny To Professional Activities Under The Sherman Act

Under Section 1 of the Sherman Act, there appear now to be three different tests for determining whether organized professional activities are unlawful restraints of trade—the *per se* rule, the traditional full rule of reason

analysis and an intermediate, "limited" rule of reason analysis.[6] Historically, antitrust cases have been analyzed under either the *per se* rule or the rule of reason. See generally L. Sullivan, *Antitrust* 196 (1977); R. Bork, *The Antitrust Paradox* 18-19 (1978). The traditional application of the *per se* rule is based on a determination that certain types of concerted activity, often price fixing, are so inherently anticompetitive that no detailed inquiry into defendant's market power or the justifications for the defendant's action is warranted. See, *e.g.*, *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332, 351 (1982); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-214 (1940); *Kiefer Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 213 (1951).

By contrast, the inquiry under the rule of reason begins with a careful look into the relevant geographic and product market involved and the defendant's power in that market. See *Jefferson Parish Hosp. Dist. No. 2* v. *Hyde*, 104 S.Ct. 1551, 1567 (1984); *Lektro-Vend Corp.* v. *Vendo Co.*, 660 F.2d 255, 268 & n.14 (7th Cir. 1981) (and numerous cases collected therein); 2. P. Areeda & D. Turner, *Antitrust Law* 49 (1978). As one commentator has explained: "To assume power without proof might deprive both the sponsors of the arrangement and the public of a benefit, where there existed no risk of offsetting harm." L. Sullivan, *Antitrust* 191 (1977). In addition, the plaintiff must carry the burden of demonstrating that the defendant's actions have significant anticompetitive effects in that market. If they do, then the burden shifts and the defendant must demonstrate that procompetitive or other efficiency justifications exist

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[6] Although the scope of the FTC Act and the Sherman Act are not coterminous, *FTC* v. *Brown Shoe Co.*, 384 U.S. 316, 322 (1966); *FTC* v. *Motion Picture Advertising Service Co.*, 344 U.S. 392, 394-395 (1953), the Commission in its opinion clearly applied Sherman Act standards derived from this Court's cases interpreting that Act. Pet. App. 76a-77a. Accordingly, the AMA will discuss the issues in this case solely in terms of the Sherman Act.

which outweigh the anticompetitive effects. *National Society of Professional Engineers* v. *United States*, 435 U.S. at 691-692. The classic formulation of this rule of reason analysis was stated in *Chicago Board of Trade*, 242 U.S. at 242-243:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint and its effect actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

More recently, this Court has begun to employ what appears to be a third, intermediate standard of review in certain cases. See, *e.g.*, *Broadcast Music, Inc.* v. *CBS, Inc.*, 441 U.S. 1, 9, 20 (1979).[7] Thus, in *Professional Engineers*, this Court undertook a more limited rule of reason analysis. It declined to hold that the ethical rule at issue—which prohibited engineers from submitting competitive bids—was *per se* illegal. But it avoided any extended inquiry into the competitive effects of the rule on any market because it found that, even though the rule did not precisely fix prices, it nevertheless directly "'interfered with the setting of price by free market forces' [which] is illegal on its face." 435 U.S. at 692, quoting *United States* v. *Container Corp.*,

[7] Although this Court has never characterized these cases as involving a third, distinct intermediate legal standard, the FTC clearly views these cases as supporting such a conclusion. See *In re Michigan State Medical Society*, 101 F.T.C. 191, 292 (1983). See also Clanton, *The FTC and the Professions*, 52 Antitrust L.J. 209, 217 (1984).

393 U.S. 333, 337 (1968).[8] Nevertheless, in contrast to a classic *per se* analysis, the Court did examine the professional society's proffered justifications for its rule as a defense to the Sherman Act claim. But, because the engineers could not demonstrate any procompetitive justifications for their facially anticompetitive scheme directly affecting price, the Court held that the engineers' rule violated Section 1 of the Sherman Act. 435 U.S. at 694.[9]

In *NCAA* v. *Board of Regents*, *supra*, this Court again appeared to use a "limited" rule of reason analysis. The Court examined the NCAA's "television plan" for broadcasting football games of member institutions and concluded that it contained "naked restraints" on market output and price. The Court declined, however, to apply the *per se* rule in view of the NCAA's plausible contention that this form of self-regulatory restraint was necessary to ensure that any product (in that case amateur football) existed at all.

The NCAA argued that its television plans had no significant anticompetitive effect because the record did not support a finding of market power. Quoting *Professional Engineers*, the Court rejected this argument, holding that

> [a]s a matter of law, the absence of proof of market power does not justify *a naked restriction on price or output*. To the contrary, when there is an agree-

[8] Although the Court in *Professional Engineers* appears to have applied a limited rule of reason, the opinion has been read as having applied a *per se* test to the ban on competitive bidding. See *Arizona* v. *Maricopa County Medical Society*, 457 U.S. at 362 (Powell, J., dissenting) ("In *Professional Engineers*, we held unlawful as a *per se* violation an engineering association's canon of ethics that prohibited competitive bidding by its members").

[9] In *NCAA* v. *Board of Regents*, *supra*, the Court modified, in part, the strictness of the *per se* standard by suggesting that even "[*p*]*er se* rules may require considerable inquiry into market conditions before the evidence justifies a presumption of anticompetitive conduct." 104 S.Ct. at 2962 n.26.

ment not to compete in terms of price or output, "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement."

104 S.Ct. at 2965, quoting, 435 U.S. at 692 (emphasis added). The Court relied upon the district court's unchallenged finding that price and output were unresponsive to consumer preference as a result of the NCAA's restrictions, and concluded: "We have never required proof of market power in such a case. This naked restraint on price and output requires some competitive justification even in the absence of a detailed market analysis." *Ibid.*

B. Fundamental Issues Remain Open Regarding The Application Of The Sherman Act To The Activities Of Professionals and Professional Associations

This Court has not yet determined precisely what professional conduct triggers which standard of review—a *per se* rule, a "truncated" rule of reason analysis or the traditional *Board of Trade* rule of reason analysis. The development of the law has properly evolved slowly because the Court has reviewed only a few extreme types of anticompetitive actions undertaken by organized professionals. *Goldfarb* and *Maricopa County* were pure price-fixing cases and *per se* rules were appropriate. *Professional Engineers* involved a blatant attempt to interfere with competition in setting prices, and *NCAA* involved a conspiracy to set prices and restrict output. These cases present a distorted picture of professional self-regulation because most efforts to enhance quality medical care do not facially restrict price or output but do clearly promote patient care.

1. The issue of what type of conduct triggers which standard of review is of critical importance to professional associations because the scope of the Sherman Act as it applies to "boycotts" or "concerted refusals to deal" is extraordinarily broad. Indeed, the Act can be alleged to apply to virtually any organized, professional effort to

enhance quality of service. See *St. Paul Fire & Marine Ins. Co.* v. *Barry*, 438 U.S. 531, 541 (1978).[10] For instance, the AMA shares medical school accreditation functions with other professional societies. See *In re American Medical Ass'n*, 94 F.T.C. 701, 706 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982). Any school denied accreditation potentially could sue claiming that an exclusionary decision is anticompetitive.[11] The AMA and other medical or health care associations also recognize specialities and certify practitioners as specialists. Any individual excluded from a specialty can claim that the exclusion is anticompetitive.[12] Members of the AMA routinely engage in peer review as part of the hospital staff privilege process, which is a direct means of ensuring that all physicians with hospital privileges meet minimum standards of professional competence. A physician who is denied staff privileges or who has privileges revoked can sue the hospital and the physicians alleging a conspiracy to exclude him from the market of in-patient hospital care.[13]

The importance of these and other professional activities is unquestionable. For instance, it makes little sense for society to rely solely upon medical malpractice law-

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[10] Indeed the Court last Term demonstrated its uneasiness with the potential breadth of the boycott-concerted refusal to deal doctrine by making clear that not all conduct, even conduct by strictly commercial entities, that can be fitted within the definition of a boycott is *per se* illegal. *Northwest Wholesale Stationers, Inc.* v. *Pacific Stationery & Printing Co.*, 105 S.Ct. 2613, 2619-2620 (1985).

[11] See *Marjorie Webster Junior College* v. *Middle States Ass'n of Colleges and Secondary Schools*, 432 F.2d 650 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970) (school denied accreditation unsuccessfully sued accrediting agency alleging an illegal boycott).

[12] See *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d 1479 (D.C. Cir. 1984) (case remanded for trial of dentist's challenge to exclusion from periodontology specialty as a boycott.

[13] See Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 596 & n.2 (1980) (and cases collected therein).

suits as the only means to encourage quality health care. This after-the-fact response does not relieve the suffering of the individual injured by inadequate care and the process of obtaining compensation is in many instances both uneconomical and inefficient. Rather, the medical profession should be encouraged to use its expertise to promote high quality care and to weed out incompetent physicians. The medical profession performs this valuable service by promoting quality in training, in accreditation and in peer review. See, *e.g.*, Leffler, *Physician Licensure: Competition and Monopoly in American Medicine*, 21 J. L. & Econ. 165, 173 (1978); Leland, *Quacks, Lemons, and Licensing: A Theory of Minimum Quality Standards*, 87 J. Pol. Econ. 1328, 1329-33 (1979).

All of these activities are designed to serve important pro-consumer interests. They do not restrict output, but rather enhance the quality of all levels of output or reduce the costs of producing market-determined levels of output. In addition, they provide consumers with the basic assurance that the professional to whom they take their problem is fully qualified to exercise appropriate professional judgment. See *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d at 1491; cf. *Goldfarb* v. *Virginia State Bar*, 421 U.S. at 788 n. 17; *Arizona* v. *Maricopa County Medical Society*, 457 U.S. at 349. In recognition of the public service that professional organizations provide, most lower federal courts have applied the traditional rule of reason analysis to professional self-regulation and have held that "traditional antitrust concepts are flexible enough to permit [professional organizations] sufficient breathing space within which to carry out the[ir] mandate . . ." *Silver* v. *New York Stock Exchange*, 373 U.S. 341, 360 (1963).[14]

[14] See, *e.g.*, *Kreuzer* v. *American Acad. of Periodontology*, 735 F.2d at 1484-1495; *Wilk* v. *AMA*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 104 S.Ct. 2398 (1984); *Pontius* v. *Children's Hospital*, 552 F. Supp. 1352, 1369-1370, 1371-1372 (W.D. Pa. 1982); *Paralegal Institute, Inc.* v. *ABA*, 475 F. Supp. 1123, 1129-1130 (E.D.N.Y. 1979), *aff'd per curiam*, 622 F.2d 575 (2d Cir. 1980). See also Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 647 (1980).

Under the traditional rule of reason analysis, lower federal courts have recognized that justifications exist for allegedly anticompetitive activity of professionals engaged in self-regulation. They have found that some professional activities have procompetitive effects which outweigh their anticompetitive effects. When a physician is denied staff privileges or a training program has its accreditation withdrawn, the resulting loss of one *competitor* is not an unlawful anticompetitive effect under the Sherman Act. Even though an individual competitor may be harmed, competition can be promoted by encouraging patients to make price and service comparisons without concern for whether a particular physician will satisfy minimum requirements for competence. See, *e.g.*, *Ratino* v. *Medical Service*, 718 F.2d 1260 (4th Cir. 1983); *Pontius* v. *Children's Hospital*, 552 F. Supp. 1352 (W.D. Pa. 1982); *Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd without opinion*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982).

2. These lower court decisions raise important issues which may eventually require resolution by this Court. But, because so few cases involving professional self-regulation and allegations of a concerted refusal to deal have been before the Court, many basic issues simply have not been decided. Most basically, the Court has not decided which standard—the *per se* rule, a truncated rule of reason analysis or a full-blown rule of reason analysis—should be applied to professional self-regulatory activities which can be characterized as a boycott. A related issue is how much judicial experience with an organized professional activity is necessary before determining which standard of review is appropriate. Moreover, with respect to the full rule of reason analysis, the

Court still must define which organized professional activities intended to promote quality care are "procompetitive" in an economic sense within the meaning of the rule, and whether any practice that can benefit a consumer is in that sense procompetitive.

None of these issues was decided below because the FTC used the traditional rule of reason and the court of appeals held that the FTC had not made findings adequate to define the relevant market, to demonstrate the extent of respondent's power in that market or to show that respondent's practices had any substantial effect on competition. Because of the profound effect the unresolved antitrust issues have on professional self-regulation, the Court should not reach any of them here. The FTC at the administrative level applied a full rule of reason analysis and, as we show in part II, it failed to make necessary findings under that standard. The FTC in its brief now attempts to raise an issue concerning the application of a "limited" rule of reason but, as we show in part III, the Commission's failure to apply, much less justify use of, the "limited" rule of reason at the administrative level precludes reliance on it to uphold the FTC's decision. Moreover, although the Court need not reach the issue, it is clear that this case cannot properly be analyzed under a "limited" rule of reason.

II. THE FTC, IN THE ADMINISTRATIVE PROCEEDING, APPLIED THE TRADITIONAL RULE OF REASON TO THE FACTS AND COMMITTED CLEAR ERROR IN ITS ANALYSIS

A. The FTC Purported To Apply The Traditional Rule Of Reason To Respondent's Conduct

The FTC clearly analyzed this case in terms of a full "rule of reason" standard of review. *Id.* at 77a-78a. The FTC explained the basis for its decision as follows: "To assess the legality of [respondent's] restrictions under a rule of reason analysis, we must examine their nature, purpose and effect on competition, including an assessment of any possible pro-competitive impact. *Chicago Board of Trade*, 246 U.S. at 238." Pet. App. 77a-78a. This standard was employed because respondent's practices were not intended solely to be anticompetitive; respondent had attempted to justify the rule as furthering quality of care for patients and the "boycott' affected no competitors or any buyer-seller relationship. *Id.* at 76a-77a. Under these circumstances, the FTC quite properly concluded that a full rule of reason "inquiry about competitive effects" was warranted. *Id.* at 77a. See page 5, *supra*.

In its administrative opinion, the FTC did not purport to employ any limited or truncated rule of reason analysis.[15] The FTC's reasoning in this case stands in stark contrast to its analysis in another case that was decided on the same day as this one, *In re Michigan State Medical Society*, 101 F.T.C. 191 (1983).[16] There the Commission

[15] Based on this Court's cases construing Section 1 of the Sherman Act, the FTC in other cases has clearly taken the position that some rule of reason cases are properly examined under truncated or limited standards that permit the FTC to forego conducting any precise analysis of market power or anticompetitive effects. The United States, in its *amicus* brief (at 9 n.8) in this Court in *NCAA* v. *Board of Regents*, *supra*, which was joined by the FTC, expressly relied upon the *Michigan State Medical Soc'y* case as clearly demonstrating that a "truncated" rule of reason analysis has sometimes been applied by the FTC. Other cases, however, are analyzed according to what one FTC Commissioner has described as the "full-blown rule of reason." *In re Borg-Warner*, 101 F.T.C. 863, 962 (Miller, dissenting), which requires a thorough analysis of the relevant market, the defendant's power in that market and the anticompetitive effects of the defendant's actions.

[16] The *Michigan State Medical Soc'y* case involved a refusal of physicians to deal at all with third-party payers if those payers refused to accept certain arrangements for determining physician reimbursement schedules. In its *Michigan State Medical Soc'y* opinion, the FTC pointed out the "close resemblance" between the challenged practices and "price-tampering combinations" which traditionally have been held to violate the Sherman Act. Thus, the medical society and its members had collectively attempted to

explained carefully and explicitly why no detailed analysis of market power was necessary because of the facially anticompetitive nature of the physicians' conduct. 101 F.T.C. at 292. As the FTC there stated, "a less elaborate analysis of competitive effects" is required because the activity is "so closely related to prices" that the burden immediately shifts to the defendant to justify the practices. 101 F.T.C. at 292 (1983). See *In re American Medical Ass'n*, 94 F.T.C. at 1004 (no market power analysis required because restriction on advertising is plainly anticompetitive); *In re Borg-Warner Corp.*, 101 F.T.C. 863, 962-963 (1983) (Miller, dissenting) (distinguishing truncated rule of reason from full-blown rule of reason analysis). In this case, by contrast, the Commission expressly undertook to engage in the full, traditional rule of reason inquiry.

B. The FTC Failed To Find Facts To Satisfy Basic Elements Of The Traditional Rule Of Reason Test

In light of the FTC's professed intention to analyze respondent's conduct under the traditional rule of reason standards, it is not surprising that the court of appeals' majority and Judge Fairchild, in his concurring opinion, both criticized the FTC's findings in this case and decided to remand the matter for further proceedings. Initially, the FTC made no attempt to define the relevant geographic market for respondent's services or to determine the extent of respondent's power in any market.[17]

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negotiate changes in the method of determining reimbursement, which were intended to "increase the reimbursement recovered . . . and the frequency with which the fee levels of many physicians were revised upward." 101 F.T.C. at 291. The FTC held that because the medical society was not actually setting fees the practices were not *per se* illegal. Nevertheless, as a restraint directly affecting price, the practices did not require a detailed examination of market, market power or anticompetitive effects. *Id.* at 293.

[17] If the market is defined as all of Indiana, which has 3100 dentists, Pet. App. 144a, then the 92 dentists who joined respondent obviously lacked any significant market power. Even if the relevant market is defined more narrowly, the FTC never explained what percentage of any total market belonged to respondent's members. All the FTC found was that most dentists in some geographic areas were *members* of the IDA or IFD, not that they participated in the boycott. Pet. App. 84a-85a. As the cases cited previously clearly indicate, no analysis of whether a restraint is anticompetitive is meaningful without an initial determination of market power. See page 11, *supra*.

The only real finding in the FTC's opinion was that two insurance companies had modified their practices in response to the concerted refusal to supply x-rays and that one insurance company accumulated a substantial number of unprocessed claims because it received no x-rays from respondent's members. See page 5 *supra*. But without knowing how many total claims that company processed or how much of the dental market that company was responsible for, it is impossible to say what, if any, effect on competition there was.

As the court of appeals correctly observed about the FTC's findings (Pet. App. 38a):

> The record contains no substantial evidence nor thorough analysis of the total number of dental patients within the relevant market; the percentage of dental patients covered by group dental health care plans within the relevant market; the availability and proximity of dentists from surrounding areas of Indiana; the fees charged those patients covered by group dental health care plans, as compared to the fees charged patients without such coverage, within the relevant market; the policy of non-IFD member dentists in dealing with group dental health care insurers within the relevant market; or the general policy of dental insurers throughout the State of Indiana in examining a proposed or completed course of dental treatment for purposes of benefit determination.

The FTC's failure to analyze market power is, by itself, fatal to the FTC's holding that respondent violated Section 1 of the Sherman Act.

Assuming, however, that the FTC had properly made findings on market power, its analysis was still flawed

because it failed to demonstrate any anticompetitive effects. The FTC merely asserted that, without any horizontal agreements, there would have been some theoretical pressure for dentists to compete for business by supplying x-rays. Pet. App. 85a. But there is no evidence of any pressure to compete on this aspect of the dentists' service. No such pressure manifested itself during the period respondent's x-ray policy was in effect. Although the FTC did not define any geographic market, the ALJ found that dentists in each area where respondent was influential did not join respondent or follow its x-ray policy. If the FTC's assumption were correct, then these dentists who supplied x-rays to insurers should have exerted strong pressure on some of respondent's members to bolt in order to meet that competition. But the FTC made no finding that respondent ever employed *any coercion* to force dentists to follow its x-ray policy or had even adopted any policy for responding to *any* defections by member dentists. Nor did the FTC make any findings that respondent employed any coercion against dentists who did not join or follow respondent's policy.

The court of appeals therefore properly vacated the FTC's order, which was predicated upon the assumption that "competitor dentists were freed to some extent from . . . market forces," when there was absolutely no evidence that such competition existed. Judge Fairchild was surely correct that (Pet. App. 49a):

> [N]o evidence was developed on the validity of an assumption that a dentist's policy of refusal or cooperation has any significance in competition among dentists, and the FTC decision fails to analyze the proposition. It may well be that evidence could be produced to support a finding that this policy is really an element of competition among dentists and that a concerted policy of refusal does work a real injury to competition. But this analysis has not been made.

There is no better proof that the FTC, in its administrative opinion, failed to analyze the record evidence concerning the Sherman Act inquiry into the nature of competition among dentists than the FTC's belated effort in its brief to revisit the record and to cite evidence relevant to that issue which the Commission did *not* cite in its own opinion. Thus, for instance, the entire discussion on pages 29-30 of the FTC's brief of "[t]he conspirators' documents," which is designed to "prove" that the x-ray policy had "competitive consequences," is based on trial exhibits reproduced in the appendix to the FTC's petition. But this evidence, which is not cited in the findings of the Commission in its administrative opinion, cannot rehabilitate the FTC's inadequate analysis.[18] *FTC* v. *Sperry & Hutchinson Co.*, 405 U.S. 233, 248 (1972); *Zuber* v. *Allen*, 396 U.S. 168, 196 (1969). This Court should not sift through the record *de novo*; that function is solely the FTC's, and its failure to make the necessary findings in its administrative opinion requires its decision to be set aside and the case to be remanded to the agency for further proceedings. *Ibid.*

If, contrary to the AMA's submission, the Court concludes that the FTC made adequate findings based on record evidence to support its holding that respondent's practices had anticompetitive effects, the Court should reverse and remand solely on that ground. There is no basis for the Court in this case to decide what role patient care concerns play under the antitrust laws as applied to pro-

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[18] In its brief to this Court, the FTC does not even attempt to explain what the relevant market is or how much power respondent had in any market. The FTC notes (Br. 32) that, in one county and for one of respondent's chapters, respondent's membership included all but a few dentists. But the FTC does not even attempt to explain how mere membership converts into market power to implement a boycott which some competitors did not join. The FTC in its brief (FTC Br. 32) also mentions possible reprisals by respondent, but the FTC in its administrative opinion made no findings of any attempts at coercion by respondent or any of its members.

fessional activity.[19] The court of appeals clearly did *not* hold that respondent's ethical concerns would exonerate respondent if its practices were found to be anticompetitive. Moreover, the court apparently could not have so held in this case because respondent apparently did not present any evidence that its practices were genuinely intended to promote patient care or that they had that effect. Pet. App. 95a-96a. For reasons the AMA already has discussed, this Court should not attempt to decide any broad legal issues which will profoundly affect professional self-regulation when the factual record concerning genuine patient care considerations is inadequate, and when the court below made no effort to decide any patient-care issue.

III. IN ITS BRIEF TO THIS COURT, THE FTC ERRONEOUSLY ATTEMPTS TO APPLY A "TRUNCATED" RULE OF REASON TO THE FACTS OF THIS CASE

The FTC's brief is somewhat peculiar because it never actually informs the Court either what antitrust standard —traditional rule of reason or limited rule of reason— *should* be applied to respondent's practices or even what legal standard the FTC itself applied at the administrative level. Obviously, the issue of when a limited rule of reason analysis, as opposed to a full-blown rule of reason, should be applied is an evolving issue of major impor-

[19] The FTC attacks at length (FTC Br. 36-43) the discussion in the court of appeals majority's opinion regarding the legal, moral and ethical justifications for respondent's practices. Although references to this point in the opinion are numerous, the role this analysis played in the final decision of the court appears to have been quite limited. Because respondent's x-ray policy was at least nominally adopted for a purpose other than to restrain competition, *both the FTC and the court of appeals* held that the *per se* rule was not appropriate in this case. Within its rule of reason analysis, the court of appeals had no occasion to discuss the relevance of the ethical purpose of respondent's practices because it held that the FTC had failed to make adequate findings of market definition, market power and anticompetitive effects.

tance to the FTC. This distinction has been a major focus in other opinions of the FTC and in other briefs joined by the FTC filed in this Court. But there is virtually no substantive discussion of the law in the FTC's brief in this case. Nevertheless, the FTC's ambiguity on this issue does nothing to assist its legal position before the Court. To the extent the FTC is content to have the case decided under traditional rule of reason standards, it must lose for the reasons stated in Part II. To the extent the FTC would prefer to have this case decided under a limited rule of reason analysis, it still must lose for the reasons that follow.

A. The Commission's Failure To Use The Truncated Rule Of Reason At The Administrative Level Precludes Reliance Upon That Doctrine To Defend The FTC's Decision Here

In addition to its attempt to supply findings not made by the Commission in its administrative order, the FTC in its brief at times appears to argue (FTC Br. 25-26) that this case is a proper one for use of a "limited" or "truncated" rule of reason analysis and therefore the Commission's failure to make market power findings and findings on anticompetitive effects was excusable. The fundamental flaw in the FTC's submission to this Court is that it ignores the Commission's own analysis in its opinion.[20] The FTC at the administrative level treated this matter legally as a full, not a "truncated" rule of reason case. And, counsel for the FTC cannot now defend, nor can this Court uphold, the Commission's decision on a ground which is legally or factually different from the one employed by the Commission itself at the administrative level. See, *e.g.*, *FTC* v. *Sperry & Hutchin-*

[20] The FTC's brief is quite ambiguous as to its view of what the Commission did at the administrative level. The brief tries to defend the FTC's order under both a full and a limited rule of reason analysis without ever firmly stating which approach the FTC now believes the Commission used at the administrative level.

son Co., 405 U.S. at 249; *Zuber* v. *Allen*, 396 U.S. 168, 196 (1969); *SEC* v. *Chenery*, 318 U.S. 80, 96 (1943).

The Commission was required either to make the full findings under the traditional rule of reason test, which it did not do, or it was required to explain why respondent's conduct, which on its face did not restrict prices or output, warranted an extension of the truncated rule of reason approach of *Professional Engineers* and the Commission's own decisions. Before the FTC could apply the antitrust laws in the way its brief proposes, it was required under fundamental principles of administrative law and basic notions of fairness to the respondent to provide a reasoned explanation for employing a new legal standard that would significantly modify the burden of proof in respondent's case. See *Bowman Transportation, Inc.* v. *Arkansas-Best Freight Systems, Inc.*, 419 U.S. 281, 285-286 (1974); *FTC* v. *Sperry & Hutchinson Co.*, 405 U.S. at 249; *Citizens To Preserve Overton Park, Inc.* v. *Volpe*, 401 U.S. 402, 416 (1971). It did not. What is more, the FTC in its brief makes no attempt to discuss the complicated legal issues concerning when the limited rule of reason should be applied. If it had, it would have been forced to conclude that this case is not an appropriate one for a limited rule of reason analysis.

B. The FTC's Attempt To Apply A Truncated Rule Of Reason Analysis To This Case Is Erroneous

1. Although the Court need not reach the issue, even if the Commission had purported to apply a truncated rule of reason approach at the administrative level, its decision would clearly have been in error. This Court has generally been reluctant to apply a *per se* rule "until the judiciary obtains considerable rule-of-reason experience with the particular type of restraint challenged." *Arizona* v. *Maricopa County Medical Society*, 457 U.S. at 349 n.19. See *White Motor Co.* v. *United States*, 372 U.S. 253 (1963). Otherwise, legitimate activity might be declared illegal. The same principle applies to the limited rule of

reason analysis. Judicial experience should be required before a limited rule of reason analysis is sanctioned. A too-hasty application of a limited rule of reason, which shifts the burden of proof to the defendant without proof of significant anticompetitive effects in a defined market, could cause much legitimate professional activity which promotes the public interest to be invalidated even though it is not actually anticompetitive. The public interest is not served by interpretations of the Sherman Act with its treble damages provision that outlaw beneficial conduct or even conduct that is not procompetitive unless that conduct is almost certainly anticompetitive. See L. Sullivan, *Antitrust* 191 (1977); R. Bork, *The Antitrust Paradox* 4 (1978).

In this case, the context in which the issue arises—health care and insurance—is not one with which the Court has had much experience in the antitrust field. *Arizona* v. *Maricopa County Medical Society*, 457 U.S. at 357, 367 (Powell, J., dissenting). Indeed, the phenomenon of third party insurance for dental services became popular only in the 1970's. The FTC in its brief (FTC Br. 2-4, 24-25) discusses the economic relationships among dentists, patients and insurers as though these relationships were clearly defined, but that discussion is devoid of any record citations—or citations to any authority that could be noticed by this Court. As the court of appeals held, there are a number of unanswered questions about dentists' practices and the proper role of insurance both in this case and generally. Accordingly, this is not an area of the law that lends itself to a limited rule of reason approach.

2. In areas of judicial inexperience, the Court has nevertheless applied a *per se* and a limited rule of reason analysis if the challenged conduct was plainly anticompetitive. See, *e.g.*, *Arizona* v. *Maricopa County Medical Soc'y*, *supra*. But the Court's previous cases clearly re-

strict the limited rule of reason to situations where the potential anticompetitive effects are manifest. In *Professional Engineers*, the Court focused on the close and obvious relationship between the challenged activity and price. In *NCAA* the Court again concentrated on the facially direct effect of the concerted action on price and output. As the government argued in *NCAA* (Br. at 12; emphasis added):

> Where the practice at issue is shown to pose high anticompetitive risks because, *on its face*, it restricts output or restrains price competition, a court can and should address the above efficiency questions without conducting a "full" rule of reason analysis of market definition and market power.

See *Broadcast Music, Inc.* v. *CBS*, 441 U.S. 1, 19, n.33 (1979).

But the activity engaged in by respondent does not satisfy this requirement for imposing a limited rule of reason. As the FTC itself recognized, respondent's policy is just barely a boycott; it lacks all of the classic anticompetitive elements of a boycott. Pet. App. 76a. It does not affect any competitors of respondent, and it does not interfere with the decisions of any patients who are buyers of dental services. There is no evidence to suggest that respondent's practice is likely to result in a restriction in output of dental care services. Accordingly, respondent's practices are not properly subject to a limited rule of reason analysis under this Court's prior decisions applying that standard.

3. Nor do the arguments of the FTC justify extending the use of a truncated rule of reason to respondent's practices which do not directly restrict price or output. The FTC claims (Br. 25) that respondent's actions resemble "two types of restraints that previously have been found to violate the antitrust law." First, the FTC compares (FTC Br. 25) this case with *Paramount Famous Lasky Corp.* v. *United States*, 252 U.S. 30 (1930), in which a

group of distributors, who directly controlled 60% of the national market in films and represented 90% of that market, coerced exhibitors to agree to an arbitration provision under pain of being boycotted by the entire group of distributors. The FTC's reliance on *Famous Lasky* is seriously misplaced. The Commission in its *own* opinion discussed *Paramount Famous Lasky* and did not find it controlling. Pet. App. 75a. Moreover, the FTC's assumption in its brief that insurers stand in the shoes of the patient being insured was both rejected by the FTC below when it held that respondent's practices did not affect consumers (*id.* at 76a) and, in any event, is inaccurate.

While the insurer may fairly represent some of the "buyer's" interests, it clearly has interests very distinct from the actual purchaser of dental services. The insurance company does not have to live with the final product and therefore will tend to weigh purely economic considerations much more heavily than the buyer. In addition, the insurer may have greater bargaining power than a single buyer. Finally, there are different kinds of provider-insurer relationships and different kinds of insurance arrangements. In *Pennsylvania Dental Ass'n* v. *Medical Service Ass'n of Pennsylvania*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 2021 (1985); and *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 105 S.Ct. 2040 (1985), cited by the FTC (FTC Br. 24-25), the insurers had direct contractual relationships with the physicians which made the insurers appear like purchasers of the physicians' services. The FTC made no findings that similar relationships existed between respondent's members and any insurers. Accordingly, the FTC has not shown that it is reasonable to compare the provider-insurer relationships in this case with any buyer-seller relationships.

Second, the FTC asserts (Br. 26) that respondent's conduct "denied buyers information required for cost containment purposes," which the FTC claims is "similar" to the restraint in *Professional Engineers*, 435 U.S. at 692-693, where no competitive bids were allowed. This

argument is also flawed. First, as a factual matter, the FTC in its opinion expressly declined to consider complaint counsel's contention that "patients were deprived of information that might lead them to switch dentists" (Pet. App. 86a) because the initial complaint did not clearly allege such harm. *Id.* at 87a. Second, there is no real comparison between the direct restraint on information to a buyer in *Professional Engineers* where the engineers were expressly forbidden to supply competitive bids to the consumer and respondent's x-ray policy which was directed solely at insurers and which was never shown to have affected any patient.

Contrary to the FTC's position in its brief, the Commission correctly concluded, albeit *sub silentio*, in its opinion that this was not an appropriate case for a truncated rule of reason analysis. Accordingly, the Court should reject the FTC's *post hoc* arguments on this issue in its brief to this Court and not extend use of the limited rule of reason beyond cases that clearly restrain price or output and are thus facially anticompetitive.

CONCLUSION

The judgment of the court of appeals vacating and remanding the FTC's order should be affirmed.

Respectfully submitted,

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BRIEF

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No. 84-1809

In the Supreme Court of the United States

OCTOBER TERM, 1985

FEDERAL TRADE COMMISSION, PETITIONER,

v.

INDIANA FEDERATION OF DENTISTS, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN COLLEGE OF RADIOLOGY

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BRIEF AMICUS CURIAE OF THE AMERICAN COLLEGE OF RADIOLOGY

INTEREST OF THE AMERICAN COLLEGE OF RADIOLOGY AS AMICUS CURIAE

The American College of Radiology is a not-for-profit professional association with approximately 15,000 U.S. physician members who specialize in radiology. The activities of the College include research and evaluation of issues in the radiologic health sciences and educational programs for its members and others. The College regularly communicates with and advises various branches of federal and state government on these issues and promulgates policy statements, practice guidelines, and principles of professional ethics for the benefit of its membership and the public.

Like many of its counterpart societies in the medical community, the College provides a valuable service to physicians and the

public through the dissemination of information and the promulgation of guidelines and standards relating to the practice of radiology. The College has an interest in insuring that the many legitimate activities in which it engages are not challenged or rendered suspect due to misinterpretation or misconstruction of longstanding antitrust principles.

It is the College's view that the instant case does not call on the Court to decide any new questions of substantive antitrust law; existing decisions of this and other Courts provide a settled antitrust framework for this Court's decision herein. Rather, this case properly presents only questions regarding the scope of review of FTC decisions, turning entirely on matters of adequacy of evidence in the record.

This brief is filed in support of respondent. The consent of both parties hereto has been obtained and is being separately filed herewith.

SUMMARY OF ARGUMENT

The FTC incorrectly contends that the court of appeals misapplied antitrust law by allowing anticompetitive behavior to be excused by other considerations. On the contrary, the court of appeals squarely based its decision solely on the FTC's failure to prove any anticompetitive effect in a relevant market. The only issues presented here, therefore, are those regarding that failure of proof and the standard of judicial review over the FTC's factual determinations.

The antitrust principles governing this case are well settled. Nonprice restraints grounded on considerations of professional ethics or public service are to be judged under the Rule of Reason, not under a per se rule. Under the Rule of Reason, the defendant need not prove any procompetitive effect; rather, the burden of proof is on the FTC to prove anticompetitive effect.

In evaluating a particular ethical restraint in the health care field, it must be borne in mind that in many instances competition is enhanced by efforts to safeguard product quality and public confidence. Physicians rely on professional organizations to assist their quality-monitoring activity by researching and stating standards of quality care. Individual practitioners lack the resources to make individual investigations. Such joint standard-setting is procompetitive, much as are industry standards of safety or quality in commercial settings; they simply provide a yardstick by which each competitor's performance can be judged.

ARGUMENT

I. THE FTC INCORRECTLY CONTENDS THAT THE COURT OF APPEALS MISAPPLIED GOVERNING ANTITRUST PRINCIPLES.

In its Petition for Writ of Certiorari, the FTC contended that the court of appeals created "a *de facto* exemption for group boycotts by professionals that purportedly further 'legal, moral, and ethical' policy goals" (Pet. 8). This contention represented the principal reason why the FTC urged this Court to grant its petition. Although the FTC has toned down this argument substantially in its brief on the merits, it continues to accuse the court of appeals of improperly "Crediting IFD's Assertion Of Legal, Moral, And Ethical Justification For The Boycott". (FTC Brief 36)[1]

The FTC is mistaken in its accusation that the court below misapplied governing antitrust principles by "crediting" extraneous considerations.[2] In fact, citing repeatedly *National Society of*

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[1] The diminished attention to this point in the FTC's brief represents an acknowledgement that the only appropriate issue presented for review in this case is whether the court of appeals applied the proper standard of review of an administrative decision.

[2] The Supreme Court "reviews judgments, not opinions." *E.g., Chevron, U.S.A., Inc.* v. *NRDC,* ___ *U.S.* ___, 104 S.Ct. 2778, 2781 & n.8

Professional Engineers v. *United States*, 435 U.S. 679 (1978), the court of appeals stated that "[t]he Supreme Court precedent clearly provides that 'the inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition' " (App. to Pet. for Cert. 33a), and that "[t]he rule of reason analysis 'does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses on the challenged restraint's impact on competitive conditions' " (*id.* 34a). However, the court went on to emphasize that in a Rule of Reason case " 'a showing of anticompetitive effect in the relevant market is an essential predicate of antitrust liability' " (*id.*, quoting *Phil Tolkan Datsun, Inc.* v. *Greater Milwaukee Datsun Dealers' Advertising Ass'n*, 672 F.2d 1280, 1287 (7th Cir. 1982)).[3] It was on that principle, and no other, that the court based its reversal of the FTC's order.

(1984); *Black* v. *Cutter Laboratories*, 351 U.S. 292, 297-98 (1956). The FTC's obvious distaste for the court of appeals' use of the phrase "legal, moral, and ethical justification" may be a debatable editorial point, but as a legal matter it is inconsequential. If this Court "look[s] beyond the broad sweep of the [lower court's] language and determine[s] for [itself] precisely the ground on which the judgment rests," *Black*, 351 U.S. at 298, it will readily see that the sole question decided by the court of appeals was that there was no adequate record evidence of anticompetitive effect.

[3] Whether the court of appeals properly reviewed the findings of the Commission regarding an adverse effect on competition in the relevant market is the issue properly presented to the Court in this case. The American College of Radiology has no stake in and no position regarding whether this issue was correctly decided by the Court of Appeals. It is worth noting, however, that even Senior Judge Fairchild, who objected to some of the language in the majority opinion below, concurred in the holding that complaint counsel had failed in its burden to prove an adverse effect on competition resulting from the alleged restraint. App. to Pet. for Cert. 45a-50a.

Confronted with the explicit language of the opinion below, even the FTC was forced to admit in its brief that "the court did not state in so many words that its holding rested upon these asserted noncompetitive justifications for the IFD boycott" (FTC Brief 37). In fact, the court's holding could not have been more clear:

> Thus, we hold that, under a rule of reason analysis, *the evidence presented at the administrative hearing failed to establish that the conduct of the IFD and its member dentists had an anticompetitive effect in a relevant market*, in violation of the Federal Trade Commission Act, Section 5.

(App. to Pet. for Cert. 45a) (emphasis added; footnote omitted).

A review of the majority opinion below demonstrates that the court analyzed the "legal, moral, and ethical" considerations in the context of rejecting a per se rule of liability in this case (*id.* 31a-33a). The Commission similarly rejected a per se approach in its opinion, and the FTC neither contends that a per se rule should be applied nor denies that such considerations are relevant to whether a per se rule is appropriate. Indeed, FTC Commissioner Clanton recently pointed out that "[s]elf-regulatory efforts that promote quality of care" are often procompetitive and "should be encouraged". Clanton, The FTC and the Professions, 52 Antitrust L.J. 209, 212 (1983). It is for precisely this reason that cases like the instant one should be analyzed under the Rule of Reason.[4]

[4] An analysis of the role of these considerations in a Rule of Reason case is set forth in Section II of this brief.

Although the FTC concedes that this is a Rule of Reason case (and its brief accordingly devotes considerable effort to its argument that there was evidence of anticompetitive effect), the FTC makes the cryptic statement that "no elaborate analysis is needed to show the anticompetitive effect of the dentists' agreement at issue here." (FTC Brief 26) (footnote omitted). While the extent of "analysis" necessary in a Rule of Reason case may vary depending on the particular facts, there is no question that in such a case plaintiff bears the burden of

II. ETHICAL AND QUALITY-RELATED FACTORS ARE IMPORTANT CONSIDERATIONS IN APPLYING THE RULE OF REASON TO THE HEALTH CARE PROFESSIONS.

It is an antitrust truism that not all economic arrangements that restrain trade in one fashion or another are prohibited by § 1 of the Sherman Act. Rather, the Act prohibits only those acts or contracts that are "unreasonably restrictive of competitive conditions". *Standard Oil Co.* v. *United States*, 221 U.S. 1, 58 (1911). Thus, as this Court has often recognized, the antitrust laws permit not only ordinary garden-variety contracts, but also a wide variety of rules, practices, and accepted channels of commerce. The fundamental criterion of Sherman Act acceptability is

> whether the challenged agreement is one that promotes competition or one that suppresses competition. "The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."

Professional Engineers, 435 U.S. at 691, quoting *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918).

This limited nature of the Sherman Act's prohibition on "restraints of trade" is especially important to the health care professions, with their tradition of self-regulation, professional ethics, high standards of quality, and dedication to service to the public. A draconian application of the Act could spell the extinction of those fine traditions. Fortunately, however, the precedents establish substantial leeway for such meritorious professional efforts. They command only that such activities not be unreasonably anticompetitive.

It is now settled that there is no absolute exception from the antitrust laws for the learned professions. *Goldfarb* v. *Virginia*

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demonstrating that the restraint had an adverse effect on competition in a relevant market.

State Bar, 421 U.S. 773 (1975). Moreover, certain manifestly anticompetitive activity, such as price-fixing, is per se illegal for the professions as for other industries. *Id.*; *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982). It is equally settled, however, that the professions may not properly be treated as "just another industry" for all purposes. The Court first noted this point in *Goldfarb*:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. *The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.*

421 U.S. at 788-89 n.17 (emphasis added). The Court has since reaffirmed that position:

> We adhere to the view expressed in *Goldfarb* that, by their nature, professional services may differ significantly from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition, and thus fall within the Rule of Reason.

Professional Engineers, 435 U.S. at 696 (footnote omitted); and see *Maricopa*, 457 U.S. at 348-49. In *Maricopa*, the Court (citing *Goldfarb* and *Professional Engineers*) pointed out that a restraint would merit more generous consideration under the Rule of Reason where it was grounded on a profession's "public service or ethical norms". (No such justification was claimed for the restraint there at issue, however.)

From these decisions can be distilled three key principles governing the application of the antitrust laws to the health care professions. The first is that nonprice restraints grounded on

considerations of professional ethics or public service are to be judged under the Rule of Reason, not under a per se rule. *E.g.*, *Weiss* v. *York Hospital*, 745 F.2d 786, 820-21 & n.60 (3d Cir. 1984), *cert. denied*, 105 S.Ct. 1777 (1985); *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d 1479, 1491-92 (D.C. Cir. 1984). Such caution is necessary because medicine is a field in which "more than purely economic values are at stake." *Kartell* v. *Blue Shield*, 749 F.2d 922, 931 (1st Cir. 1984), *cert. denied*, 105 S.Ct. 2040, 2049 (1985); accord, *Wilk* v. *American Medical Ass'n*, 719 F.2d 207, 227 (7th Cir. 1983), *cert. denied*, 104 S.Ct. 2398 (1984). The point is not that ethical or public-service concerns will necessarily excuse anticompetitive conduct, but rather that there is a very real danger that prohibitions intended to restrict only anticompetitive conduct may strike too broadly and thereby inhibit other, beneficial conduct. The acknowledged social value of professional self-regulation and self-improvement demands that a restraint based on public service or ethical norms must not be held illegal unless, on a thorough and careful analysis of the facts, that restraint actually does have an unjustifiably anticompetitive effect. The Rule of Reason is the proper tool for such an inquiry. See also *Professional Engineers*, 435 U.S. at 699-701 (Blackmun, J., concurring in part and concurring in the judgment); *United States* v. *Oregon State Medical Society*, 343 U.S. 326, 336 (1952).

Second: The Rule of Reason does not require that the proponent of an ethical rule (or any other restraint, for that matter) affirmatively prove that the rule is *pro*competitive; rather, the Sherman Act prohibits only those restraints that are unreasonably anticompetitive. If a restraint is neutral with respect to competition, or if the evidence is inconclusive as to the net effect on competition, the restraint is not unlawful. The burden of proof is on the plaintiff to establish the elements of a Rule of Reason antitrust case, including anticompetitive effect. *E.g.*, *Jefferson Parish Hospital District No. 2* v. *Hyde*, U.S. , 104 S.Ct. 1551, 1567-68 (1984); and see *id.* at 1575 n.13 (O'Connor, J., concurring in the judgment); *Paschall* v. *Kansas City Star Co.*, 727 F.2d 692, 701-02 (8th Cir.) (*en banc*), *cert. denied*, 105 S.Ct. 222 (1984); *Gough* v. *Rossmoor Corp.*, 585 F.2d 381, 385 (9th Cir. 1978), *cert. denied*, 440 U.S. 936 (1979). See also *United States* v. *Arnold, Schwinn & Co.*, 388 U.S. 365, 374 n.5 (1967). Only after the plaintiff carries the burden of proving anticompetitive effect is the defendant called upon to show that the challenged restraint is justified by countervailing considerations. *E.g.*, *NCAA* v. *Board of Regents*, U.S. , 104 S.Ct. 2948, 2967 (1984); *Wilk*, 719 F.2d at 227.

Third: In determining whether a particular ethical restraint "may serve to regulate and promote ... competition", *Professional Engineers*, 435 U.S. at 696, it must be borne in mind that in many instances competition is enhanced by efforts intended to safeguard product quality in order to protect the public and enhance confidence in the product. Of course, the Sherman Act will not tolerate a purported "quality-enhancement measure" that operates solely by preventing professionals from competing against one another. *Id.* at 693-94. Not all quality- or safety-related restraints are of this character, however, as the *Professional Engineers* Court recognized. *Id.* at 696 n.22. *Cf. Jefferson Parish*, 104 S.Ct. at 1575 (O'Connor, J., concurring in the judgment) (discussing how tie-in between operating-room services and anaesthesiology improves patient care); *Neeld* v. *National Hockey League*, 594 F.2d 1297 (9th Cir. 1979).

This case implicates an aspect of professional practice in which quality and safety concerns are particularly salient—the working relations between a practicing professional and other professionals, whether from the same or a contiguous discipline.[5] These

[5] Respondent's basic contention in this case is that by making judgments as to diagnosis and treatment from necessarily inadequate information, insurance carriers are exercising (or attempting to exercise) improper and unprofessional influence over the professional judgments of attending dentists.

inter-professional dealings arise in any number of ways. Several surgeons, nurses, and anaesthesiologists work together in an operation. A general practitioner consults with a radiologist and an internist to help him to reach a diagnosis and prescribe a course of treatment for his patient. A physician seeks a second opinion—or, most broadly, simply refers his patient to another doctor in the same or another discipline.

Such professional collaboration necessarily entails some discrimination on the part of physicians as to whom they will work with, and how, in seeking to provide the best possible care for their patients. For example, physicians may discriminate against particular individuals whose professional qualifications are doubted; they may limit the scope of participation on the part of persons from another discipline (especially nonphysicians); or they may flatly refuse to deal with a profession believed to be medically unsound. Such "discrimination" may well have an adverse effect on the economic well-being of the disfavored individuals. Yet professional actions of this kind are an essential part and parcel of the services that a physician offers to his patients. He is expected (indeed, obligated) not merely to perform competently himself, but also to assure that others providing care at his direction to his patient are fully qualified to do so. The Sherman Act does not require that physicians debase the quality of their own product or the well-being of their patients by collaborating with unqualified persons, in the name of preventing an adverse effect on those unqualified persons' competitive positions.

In *Wilk*, for example, the court of appeals (remanding the case due to lack of clarity in the jury instructions) upheld the propriety of action by medical doctors and organizations based upon their belief that working with chiropractors would decrease the quality of care that patients would receive. 719 F.2d at 227. Other cases have similarly established the legality of restraints based on physicians' proper concern for the quality of care provided to

patients. *E.g., Weiss*, 745 F.2d at 820-22; *Ratino* v. *Medical Service*, 718 F.2d 1260, 1262-64 (4th Cir. 1983); *Smith* v. *Northern Michigan Hospitals, Inc.*, 703 F.2d 942, 953-54 (6th Cir. 1983); *Pontius* v. *Children's Hospital*, 552 F.Supp. 1352, 1369-70 (W.D.Pa. 1982); *Robinson* v. *Magovern*, 521 F.Supp. 842, 919-20 (W.D.Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982); *cf. Virginia Academy of Clinical Psychologists* v. *Blue Shield*, 624 F.2d 476, 485-86 (4th Cir. 1980) (pointing out that a properly drawn requirement that psychologists consult with physicians would be procompetitive as assuring proper care), *cert. denied*, 450 U.S. 916 (1981).

The antitrust laws do not forbid restraints essential "to preserve the character and quality of the 'product,'" *NCAA*, 104 S.Ct. at 2961. Physicians are entitled to take appropriate and effective steps to ensure that the care provided to their patients (whether by themselves or others) is competent and of high quality. The Sherman Act does not command them to refrain from such steps—even if they could arguably be characterized as a "boycott" of a competing doctor or other professional who cannot meet the quality standards demanded. This result is procompetitive because it permits physicians to offer a product otherwise unavailable—namely high-quality, reliable health care.

The participation of professional organizations such as the American College of Radiology is of critical importance to this quality-monitoring activity. Indeed, it is among the primary missions and functions of such organizations to address problems of common and mutual concern to their members, including matters of maximizing and safeguarding the quality of care. Professional organizations serve to identify significant areas of genuine technical or ethical controversy, to draw attention to them within the profession, to sponsor and conduct research and educational efforts, and to facilitate debate and the formation of a consensus as to how their members can best assure that their conduct is in keeping with sound principles of medical practice.

Likewise, a key function of such organizations is to undertake efforts to educate the public on matters of concern relating to the quality and cost of health care. See *Kreuzer*, 735 F.2d at 1488.

Professional organizations are indispensable to this market-enhancing function, for only by a cooperative, broadly supported effort can the work be done. Consider, for example, a controversy within the profession over the effectiveness and ethicality of a new, highly invasive technique of diagnosis or treatment. The average practicing physician does not have the time or resources to conduct his own, individual investigation into the merits of the new proposed technique. (Even if each physician could and would do so, the inefficiency of such duplication is obvious.) Instead, members of the medical community quite properly rely on recognized professional organizations such as the College for research and guidance. Such investigative and standard-setting efforts must be done jointly, therefore, because otherwise they cannot be done at all.

Indeed, even in more purely commercial settings the courts have upheld efforts by industry organizations to establish standardized specifications, grades, or safety criteria for products. Such beneficial activities are stricken down only if they are manifestly unreasonable or if they are discriminatorily applied.[6] Arguably, such standard-setting is "anticompetitive" in a trivial sense; the existence of standards supposes that there are standard

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[6] *ECOS Electronics Corp.* v. *Underwriters Laboratories*, 743 F.2d 498, 501-02 (7th Cir. 1984), *cert. denied*, 105 S.Ct. 1178 (1985); *Eliason Corp.* v. *National Sanitation Foundation*, 614 F.2d 126, 128-30 (6th Cir.), *cert. denied*, 449 U.S. 826 (1980); *Structural Laminates, Inc.* v. *Douglas Fir Plywood Ass'n*, 261 F.Supp. 154 (D.Or. 1966), *aff'd per curiam*, 399 F.2d 155 (9th Cir. 1968), *cert. denied*, 393 U.S. 1024 (1969); *Rooftire Alarm Co.* v. *Royal Indemnity Co.*, 202 F.Supp. 166 (E.D.Tenn. 1962), *aff'd mem.*, 313 F.2d 635 (6th Cir.), *cert. denied*, 373 U.S. 949 (1963); *United States* v. *Johns-Manville Corp.*, 1967 Trade Cas. (CCH) ¶72,184, at p. 84,251 (E.D.Pa. 1967); *United States* v. *Johns-Manville Corp.*, 259 F.Supp. 440, 453-54 (E.D.Pa. 1966).

and nonstandard items, and those who produce below the standard of quality or safety can expect to be penalized in the marketplace. If adopted and applied in good faith, however, such efforts to establish industry consensus are procompetitive. Their purpose and effect is to create a yardstick by which each competitor's performance can be judged by consumers. In this sense, industry standards are no more anticompetitive than is a uniform system of weights and measures; they increase the information available in the market and make that information more useful and comprehensible. Any supposed "anticompetitive effect" they may have is, in truth, no more than the natural penalty paid by producers of inferior goods and services, once their lesser quality is made visible. In the Court's words, such standards "serve to regulate and promote . . . competition". *Professional Engineers*, 435 U.S. at 696.[7]

These principles are equally applicable to standards of care and service in the health care field and other professions. See, *e.g.*, *Nara* v. *American Dental Ass'n*, 526 F.Supp. 452, 457-58 (W.D.Mich. 1981); *Paralegal Institute, Inc.* v. *American Bar Ass'n*, 475 F.Supp. 1123, 1128-31 (E.D.N.Y. 1979), *aff'd mem.*, 622 F.2d 575 (2d Cir. 1980).

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[7] Industry standards also facilitate local regulation, whether of industries or of medical services, by providing a uniform national guideline and by relieving regulatory bodies of the need for duplicative and wasteful individual research and testing. *Eliason*, 614 F.2d at 129.

Conversely, the close regulation of the medical profession decreases the need for strict antitrust scrutiny by the courts. As one court said in a related area:

> While [state regulation] does not automatically carry with it antitrust immunity, it suggests that strict scrutiny is less likely to be necessary to prevent the unwarranted exercise of monopoly power. Of course, administrative regulation is a highly imperfect process. But, regulation by judicial decree is not necessarily preferable.

Kartell, 749 F.2d at 931 (citation omitted).

Indeed, the need for standard-setting and self-regulation is exceptionally great in the medical marketplace. More now than ever before, health care is a field of bewildering complexity, high technology, and rapidly expanding knowledge—all far beyond the ability of the average consumer to follow or understand. To resume our prior illustration, if individual physicians cannot be expected to investigate a new proposed diagnostic technique, still less can one expect such an effort from lay consumers. Patients necessarily rely on their own doctors or hospitals to advise and assist them in securing qualified and competent health care, whether by referral, by consultation, or simply by peer review and self-policing of medical staffs. See *Ratino*, 718 F.2d at 1263-64. Physicians and hospitals, in turn, depend on professional organizations such as the American College of Radiology to investigate and formulate the standards of quality by which all competitors within the profession may be judged.[8] Without such cooperative efforts by recognized professional organizations, quality competition within the health care market would be seriously diminished and perhaps nearly impossible. See *Pontius*, 552 F.Supp. at 1365-66.[9]

The Sherman Act's restrictions "do not seek to establish a mere delusive liberty . . . by making impossible . . . the adoption of reasonable measures to protect [commerce] from injurious and destructive practices and to promote competition upon a sound basis." *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 599 n.40

[8] Statements of a professional consensus as to the quality of care to be expected from a competent physician are also helpful to individual practitioners in their efforts to avoid liability for malpractice or misconduct. *Cf. Tripoli Co.* v. *Wella Corp.*, 425 F.2d 932, 938 (3d Cir.)(*en banc*), *cert. denied*, 400 U.S. 831 (1970), cited by the Court in *Professional Engineers*, 435 U.S. at 696 n.22.

[9] *Cf. Jefferson Parish*, 104 S.Ct. at 1566 & n.45 (discussing market imperfections in health care); *Maricopa*, 457 U.S. at 360-61 (Powell, J., dissenting); *Virginia State Board of Pharmacy* v. *Virginia Citizens Consumer Council*, 425 U.S. 748, 773 n.25 (1976).

(1976)(plurality opinion of Stevens, J.), quoting *Appalachian Coals, Inc.* v. *United States*, 288 U.S. 344, 360 (1933). In the medical field, perhaps more than in any other market, the promotion of sound competition requires that physicians, through their professional organizations, make efforts to investigate and publicize appropriate standards of conduct in new or controversial areas of practice. See, *e.g.*, *Wilk*, 719 F.2d at 227. Sound competition likewise requires that such organizations and their members conduct fair and vigorous peer review and self-regulation to assure that they do not harbor bunglers and cheats within their ranks. See, *e.g.*, *Ratino*, 718 F.2d at 1263-64. The Sherman Act should not and does not prohibit such beneficial and procompetitive activity.

CONCLUSION

This case does not require any new antitrust law; the precedents (and even the FTC itself) plainly support the legal principles on which the court of appeals relied. The sole question for decision in this Court is whether the record contains sufficient evidence of anticompetitive effect to support the FTC's judgment.

Respectfully submitted.

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BRIEF

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In the

Supreme Court of the United States

October Term, 1985

FEDERAL TRADE COMMISSION,

Petitioner,

v.

INDIANA FEDERATION OF DENTISTS,

Respondent.

On Writ Of Certiorari To
The United States Court of Appeals
For The Seventh Circuit

BRIEF AMICUS CURIAE OF THE AMERICAN DENTAL ASSOCIATION IN SUPPORT OF RESPONDENT INDIANA FEDERATION OF DENTISTS

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I.

STATEMENT OF INTEREST AND STATEMENT OF CASE

This Amicus Brief is being filed by consent of the parties.[1]

The American Dental Association ("ADA") is an Illinois not-for-profit corporation with some 122,000

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[1] Appendix 1a-2a contains the parties' consent.

fully privileged dentist members who are licensed to practice in the States of the United States, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States. ADA is a purely voluntary association.

The ADA is interested in the issue of the antitrust standards applicable to professionals because ADA's object and purpose are to "encourage the improvement of the health of the public and to promote the art of science of dentistry." In order to fulfill its object, ADA must engage in forms of self-regulation which could be chilled by an application of the antitrust laws which is insensitive either to the differences between professions and other business pursuits or the need to maintain ethical and professional standards.

II.
SUMMARY OF THE ARGUMENT

This Court has recognized consistently that because of the nature of the professions, antitrust concepts developed in industrial contexts may not be applied automatically to them. This is not because good intentions may overcome manifestly anticompetitive actions (and consequently, price fixing by professionals is unlawful, *per se*), but rather this Court has recognized that the need for self-regulation, ethical standards and quality of care standards may alter the nature of the competition at issue and introduce inevitably other considerations which must also be examined by the Courts. In this case, where the activity at issue is not manifestly anticompetitive, the rule of reason is applicable. Under that standard, the Seventh Circuit ruled properly that the Federal Trade Commission failed to carry its burden of proving that the restraints at issue were anticompetitive.

III.
ARGUMENT

This Court Has Recognized Consistently That Application Of The Antitrust Laws To The Professions Requires Special Considerations

This Court has recognized consistently in the abstract that application of the antitrust laws to the professions requires special considerations. However, since most cases reaching this Court have involved manifestly anticompetitive conduct, those special standards have not been explored in detail. Thus, in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 787, n. 17 (1975), the Court stated:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently . . .

Of course, those special considerations do not apply to price-fixing and thus a violation was found in *Goldfarb* without any need to examine those other considerations in detail.

The standards applicable to professions were alluded to again in *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978), but because

Professional Engineers also involved manifestly anticompetitive conduct (an agreement to eliminate *all* competitive bidding) and since the defendants argued expressly that competition itself was unworkable in the profession at issue, this Court found it necessary to explain that the Sherman Act requires a focus on competition. However, even in that factual context, the Court stated that although there is no broad "exemption" for learned professions:

> We adhere to the view expressed in *Goldfarb* that, by their nature, professional services may differ significantly from other business services, and, accordingly the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote competition, and thus fall within the rule of reason (435 U.S. at 696).

Subsequent professions cases have also not required extensive analysis of the antitrust standards applicable to professions because they have either involved manifestly anticompetitive behavior such as price-fixing (*Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982)), or involved conduct which was subject to the rule of reason anyway due to the moderate market power of the defendant. *Jefferson Parish Hospital District No. 2* v. *Hyde*, —— U.S. ——, 104 S.Ct. 1551 (1984). Thus this Court has yet to apply the *Goldfarb* footnote to behavior which has some potential for an impact on competition but in which that impact may be justified.

The Various Circuit Courts of Appeals Have Adopted Sensible Standards, Which Balance Sherman Act Goals With The Need For Professionalism and Self-Regulation

In cases which fall outside such traditional *per se* violations as price-fixing or bans on solicitation and

in which there have been potential conflicts between promotion of Sherman Act competitive goals and ethically based health concerns, the lower federal courts have suggested a sensible path for balancing these goals.

Thus in *Wilk* v. *American Medical Association*, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 104 S.Ct. 2398 (1984), the Court of Appeals analyzed policies of the American Medical Association which discouraged physicians, on ethical grounds, from associating professionally with chiropractors. The Court noted that the AMA advanced a "patient care motive" for its policies:

> In the case at hand, evidence of what we have referred to as the 'patient care motive' was that when they enter into a doctor-patient relationship with specific persons, medical doctors believe it is essential to bring scientific method to bear upon diagnosis and treatment. There was evidence of this belief that to collaborate with chiropractors in the care of persons who are patients of the medical doctors is to compromise the application of scientific principles, to violate the oaths taken by the medical doctors, and to introduce risk to the health and lives of the patients for whom the medical doctors have accepted responsibility (719 F.2d at 226).

Although the Seventh Circuit was mindful that the Sherman Act generally excludes consideration of values other than the fostering of competition, it stated that a determination of a Sherman Act violation:

> . . . should not rest on insistence that the Act is indifferent to, or even hostile to, the value of permitting medical doctors to honor in their practice what they perceive to be scientific method, or indifferent to or hostile to the value of encouragement, from within the profession, to its members to honor scientific method by declining to associate with those

> thought to dishonor it. A value independent of the values attributed to unrestrained competition must enter the equation (719 F.2d at 227).

In balancing carefully these considerations, the Court suggested the following guide for jury instructions:

> The burden of persuasion is on the plaintiffs to show that the effect . . . has been to restrict competition rather than promote it. If the plaintiffs have met this burden, the burden of persuasion is on the defendant to show: (1) that they genuinely entertained a concern for what they perceive as scientific method in the case of each person with whom they have entered into a doctor-patient relationship; (2) that this concern is objectively reasonable; (3) that this concern has been the dominant motivating factor in defendants' promulgation of [the restraint] and in the conduct intended to implement it; and (4) that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition (719 F.2d at 227).

This model strikes a very sensible balance in a difficult area and maintains competition as the primary issue in the Sherman Act analysis without sacrificing entirely the goals of professionalism.

In addition, the Seventh Circuit's model is ultimately consistent with the very nature of competition in medical services. Thus, in *NCAA* v. *Board of Regents* —— U.S. ——, 104 S.Ct. 2948 (1984), the Court recognized that much NCAA regulation is appropriate and indeed a prerequisite to the type of competition offered:

> Moreover, the NCAA seeks to market a particular brand of football — college football. The identification of this 'product' with an academic tradition differentiates college football from and makes it more

> popular than professional sports to which it might otherwise be comparable, such as, for example, minor league baseball . . . . Thus, the NCAA plays a vital role in enabling college football to preserve its character, and as a result enables a product to be marketed which might otherwise be unavailable (104 S.Ct. at 296).

Thus, the restraints in *Wilk*, properly limited, go to the essence of what separates the scientific discipline of medicine from some other health care providers. Similarly, the dentists in Indiana, by seeking to insure diagnoses based upon all available medical criteria, preserve the integrity of the scientific discipline of dentistry.

Likewise, in *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d 1479 (D.C. Cir. 1984), the Court of Appeals analyzed a rule which restricted active membership in an association of dental specialists to dentists who limited their practice exclusively to the dental specialty of periodontics. Although the restraint could potentially have had some impact on competition, the United States, as *amicus curiae*, urged that the restrictions be analyzed under the rule of reason.

The District of Columbia Circuit agreed, holding that "[w]hen a conspiracy of this sort is alleged in the context of one of the learned professions, the nature and extent of its anticompetitive effect are often too uncertain to be amenable to *per se* treatment" (735 F.2d at 1492). Rather, the Court must analyze the intent and effect of the exclusionary practice under the rule of reason in order to determine whether it advances "social and moral" objects in the manner least restrictive of competition. (735 F.2d at 1443-45, citing, *Silver* v. *New York Stock Exchange*, 373 U.S. 341 (1963)). This too suggests a reasonable standard which will allow *some* factoring of legiti-

mate professional concerns within the general context of competitive goals. It also recognizes that periodontic specialists, as a group, make available in the marketplace a unique service — dentists who concentrate all of their professional energies in that specialty. Making available such a unique discipline is procompetitive.

So, also, in *Boddicker* v. *Arizona State Dental Association*, 549 F.2d 626 (1977), *cert. denied*, 434 U.S. 825 (1977), *on remand*, 680 F.2d 66 (9th Cir. 1982), *cert. denied*, 459 U.S. 837 (1982), the Ninth Circuit analyzed a challenge to rules of the American Dental Association which required that individuals joining the local and state ADA affiliates join the ADA as well. The Court held that the rule must be analyzed under the rule of reason in order to determine if it had any impact on competition, and if so, whether the restraint served directly the purpose for which professions are created — service to the public. (549 F.2d at 632). After trial on a remand, the Court affirmed a finding that [a]ppellants have presented no arguments to demonstrate any adverse effect on competition between dentists from the challenged rule." 680 F.2d 66, 68 (9th Cir. 1982). Thus the Courts of Appeals, after careful inquiry based upon developed evidentiary records, have designed sensible rules for permitting narrowly focused inquiries into goals of professionalism. These rules, by allowing scientifically oriented health professionals to safeguard the integrity of their scientific principles, ultimately promote competition.

This Court Endorses Use Of The *Per Se* Rule Only In Situations In Which The Courts Have A Great Deal of Experience

The fact that the *per se* rule has been applied sparingly to conduct involving professionals is consistent with the

general policy enunciated by this Court that the *per se* rule should be applied only to conduct that experience has proven to be anticompetitive, since the *per se* rule is a form of unrebuttable presumption. Therefore, only when the Courts are able "to predict with confidence that the rule of reason will condemn it [a specific type of restraint] is the *per se* rule applied." *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332, 344 (1982). Thus, the *per se* rule may be applied only to restraints with, "a pernicious effect on competition and lack of any redeeming virtue," *Northern Pac. Ry.* v. *United States*, 356 U.S. 1, 5 (1958). Or stated otherwise, "the *per se* rule is not employed until after considerable experience with the type of challenged restraint." *Broadcast Music, Inc.* v. *CBS*, 441 U.S. 1, 19, n. 37 (1979). The conduct at issue here, an agreement based upon dentists' belief that the use of X-rays alone subjects patients to poor treatment plans, has not been analyzed extensively by the courts, and the presumption that such an agreement is anticompetitive should not be reached casually.

The Federal Trade Commission Itself Recognized that *Per Se* Treatment Is Inappropriate

Despite the unpersuasive efforts in the Commission's brief to bootstrap the Commission's order by characterizing the restraints at issue as vaguely "similar" to conduct previously labelled unlawful *per se*, the Commission, in its opinion, did not labor under that misconception. Rather, it noted that the dentists are withholding "a tool of medical diagnosis" and that neither the Commission nor the Courts have analyzed extensively such a restraint. (101 F.T.C. at 168). Further, the Commission opinion pointed out that the defendants did offer justifications

for the restraints and that the restraints cannot be described as "naked restraints of trade with no purpose except stifling of competition," (101 F.T.C. at 168, *quoting, Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 20 (1979); and *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963)). Further, the Commission recognized that *per se* treatment of boycotts has generally been limited to those "aimed principally at excluding competitors" and that this restraint did not fit into that category. (101 F.T.C. at 168). Thus, the Commission itself recognized that *per se* treatment is inappropriate.

The United States Court of Appeals For The Seventh Circuit Determined Correctly That The Commission Failed To Carry Its Burden Of Proving An Impact On Competition

The Commission seeks to distort the opinion of the United States Court of Appeals for the Seventh Circuit by emphasizing the Court's statement that the impetus for the challenged restraint was defendants' "legal, moral and ethical" policy to achieve "quality dental care." That the Seventh Circuit's statement is accurate cannot be doubted in light of the finding of the administrative law judge that:

> IDA/IFD's campaign to keep Indiana dentists from turning patient's X-rays over to dental health care insurers has always been based principally on IDA/IFD's claim that the insurers rely largely or even solely on X-rays when making diagnoses that should not be made without recourse to *all* available diagnostic aids (including clinical oral examinations, narrative reports and all the biochemical tests now available from commercial laboratories (101 F.T.C. at 128).

Further, the ALJ found that indeed it was undisputed that there are diagnostic judgments (such as choice of restorative material) which cannot be made by the use of X-rays alone (101 F.T.C. at 130).

The Commission takes the Seventh Circuit's well-grounded comments entirely out of context. First, it ignores the fact that these comments form the basis for *agreeing with the Commission* that the conduct was not aimed primarily at excluding competitors and thus should be subject to the rule of reason (745 F.2d at 1139). Further, it is clear from the Seventh Circuit's citation of *Professional Engineers*, that it understood fully that the primary issue "is whether the challenged restraint is one that promotes competition or one that suppresses competition." (745 F.2d at 1139, quoting *Professional Engineers*, 435 U.S. at 691).

The Seventh circuit correctly states the test that under the rule of reason, the plaintiff initially must make a showing of an anticompetitive effect in a relevant market. (745 F.2d at 1140). The Court of Appeals thus notes that the Commission's stated "relevant market" was too ambiguous to allow careful analysis. Further, the Court observed that the Commission's purported "findings" about an impact upon competition "among dentists in their policy of dealing with group dental health care insurers" were mere conclusions. Assumptions regarding anticompetitive effect are the antithesis of the analysis required by the rule of reason.

The very nature of competition among health care professionals requires a more careful rule of reason analysis, not the conclusions indulged in by the Commission. The service marketed by ethical dentists is dentistry bundled with the aid of all available scientific

knowledge and diagnostic aids. Indeed that is what makes dentistry a profession. Since that distinction goes to the heart of what dentists market to the public, the Commission cannot dismiss such concerns merely by assuming, on the basis of an ill-defined relevant market, anticompetitive consequences. It is significant that the Commission brief *points to no expert economic* testimony suggesting any impact on competition.

The Commission failed to define a discernible geographic market

A basic reason why the Commission failed to demonstrate an impact on competition in a relevant market is the failure of the Commission to define a discernible geographic market. Ironically, the Commission acknowledged that "[a]s in any rule of reason case, attention must be paid to market definition in order to assess competitive effects." (101 F.T.C. at 173, n. 12). However, the Commission then makes this anomalous comment:

> No elaborate analysis is required here, since the record shows that under IDA's leadership, the conspiracy spanned many, if not most, localities in Indiana. Under the leadership of IFD, it continued to be strong in the local areas covered by the organization's three chapters. (*Id.*)

However, that is precisely where elaborate analysis *was* required. In his findings, the Administrative Law Judge noted, for example, that "CG's [Connecticut General's] Indianapolis office eventually found itself getting about 50 percent of the X-rays it needed . . ." and that "[b]y the Spring of 1976, CG was getting about 70 percent of needed radiographs from parts of Indiana where it had plants, other than Madison County as compared with less than 1 percent from Madison County." (Finding No. 76, 101 F.T.C. at 109).

To the extent that the Commission purports to rely upon a diminution in competition among dentists in cooperating with insurers' cost-containment measures, it is not at all clear that there was any state-wide impact if 70 percent of the dentists were in fact submitting X-rays. While it appears that the degree of cooperation may have been lower in Madison County (the Anderson area) and Allen County (the Ft. Wayne area), no effort was made by either the Administrative Law Judge or the Commission to explore whether those areas constitute definable markets or submarkets by themselves. Thus, the Commission failed to define a relevant market in which there was an impact on competition.

Accordingly, this case, far from being the momentous case suggested in the Commission's brief, represents nothing more than a case in which the Commission failed to sustain its burden of proof. On the other hand, if this Court wishes to give this case importance, it may do so by clearly defining the burden of proof, in a health care setting, namely, that the Commission must prove all of the elements of an antitrust violation under a Rule of Reason analysis where the activity is not palpably anticompetitive. The professions in this country are clearly entitled to this specificity from the Supreme Court. This, of course, also does not mean that ethical and quality of care standards have no place in this analysis because under appropriate circumstances, they may be shown to be either competitively neutral or procompetitive.

CONCLUSION

By reason of the foregoing, the American Dental Association respectfully requests that the decision of the Seventh Circuit Court of Appeals be affirmed.

Respectfully submitted,

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APPENDIX

IN THE
SUPREME COURT OF THE UNITED STATES

No. 84-1809

FEDERAL TRADE COMMISSION,
Petitioner,

v.

INDIANA FEDERATION OF DENTISTS,
Respondent.

CONSENT

On behalf of the Indiana Federation of Dentists, the undersigned hereby consents, pursuant to Rule 36 of the Rules of the Supreme Court, to the filing of a Brief Amicus Curiae on behalf of the American Dental Association in the above-captioned matter.

/s/
BRUCE W. GRAHAM
On Behalf of the Indiana
Federation of Dentists

Dated: November 12, 1985

IN THE

SUPREME COURT OF THE UNITED STATES

No. 84-1809

FEDERAL TRADE COMMISSION,
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Respondent.

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On behalf of the Federal Trade Commission, the undersigned hereby consents, pursuant to Rule 36 of the Rules of the Supreme Court, to the filing of a Brief Amicus Curiae on behalf of the American Dental Association in the above-captioned matter.

/s/
ERNEST J. ISENSTADT
Assistant General Counsel
Federal Trade Commission

Dated: November 12, 1985

AMICUS CURIAE

BRIEF

Supreme Court, U.S.
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No. 84-1809.

In the
Supreme Court of the United States.

OCTOBER TERM, 1985.

FEDERAL TRADE COMMISSION,
PETITIONER,

v.

INDIANA FEDERATION OF DENTISTS,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SEVENTH CIRCUIT.

Brief of Amicus Curiae
Physicians and Surgeons Association of Massachusetts, Inc.

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No. 84-1809.

In the
Supreme Court of the United States.

OCTOBER TERM, 1985.

FEDERAL TRADE COMMISSION,
PETITIONER,

v.

INDIANA FEDERATION OF DENTISTS,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT.

Brief of Amicus Curiae Physicians and Surgeons Association of Massachusetts, Inc.

Interest of Amicus Curiae.

Physicians and Surgeons Association of Massachusetts, Inc. ("PSAM") is an incorporated, non-profit labor organization comprised of Massachusetts-licensed physicians and surgeons. One of its principal objectives is to ensure that the highest quality of medical and surgical care is delivered to patients.

PSAM is a vehicle for the collective expression of its physician members' views on issues affecting the quality and provision of medical care within Massachusetts.

PSAM views this case as one of compelling significance to the medical profession and patients because, for the first time, this Court may confront the question of what factors may be considered in analyzing alleged anticompetitive conduct by health care professionals in a non-price Rule of Reason context. While PSAM is not affiliated with the Indiana Federation of Dentists "(IFD)", either financially or organizationally, and does not express any view concerning the procedural and factual issues raised in the brief for the Federal Trade Commission[1] ("FTC") filed on December 6, 1985, it does have a strong interest in a fundamental legal issue raised in the FTC brief — namely, the extent to which quality of care considerations should be taken into account in Rule of Reason cases, particularly where the medical profession is involved.

PSAM believes that the instant case is not the best vehicle for deciding this important legal issue. Because of the significance of this legal issue to the health care professions and patients, and because the FTC brief appears to raise the issue only tangentially, PSAM urges the Court to limit its decision to the facts of this case, and to refrain from addressing this legal issue generally until the issue has been more fully developed. The Court can dispose of this matter by deciding it on the narrow, procedural standard of review emphasized in the FTC brief. If the Court decides the case on this basis alone (regardless of the outcome), PSAM is not concerned how the matter is decided.

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[1] PSAM notes that the Solicitor General and the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice are signatories to the brief. For ease of reference, however, that brief will be cited herein as the "FTC brief."

If, however, the Court chooses to examine the extent to which quality of health care factors are to be weighed in a Rule of Reason analysis, PSAM wishes to bring to the Court's attention some important considerations which the Court should take into account. Specifically, PSAM wishes to make clear how the resolution of this legal issue may impact on an important medical issue. For, in addition to the legal issue presented, this case involves a current and vital health care issue that emanates from the conflicting interests of medical ethics and cost control: that is, the degree to which third-party payers' so-called "cost containment" programs interfere with the physician-patient relationship and, therefore, affect the quality of patient care. PSAM believes that undue emphasis on cost containment in many instances presents a threat to good health care in that it injects into the physician-patient relationship economic considerations which can and do result in patients being required to accept less than optimal treatment.

Summary of Argument.

The FTC brief concedes that some consideration must be given to quality of care factors in a Rule of Reason analysis. However, the FTC maintains that such factors are irrelevant unless they are specifically deemed "procompetitive." PSAM believes that quality of care factors must be given greater weight in a Rule of Reason analysis than would be the case under the narrow standard advocated by the FTC. Quality of care justifications should be viewed as separate factors in a Rule of Reason analysis and be given substantial weight in assessing the legality of collective action by physicians in a non-price context. Alternatively, quality of care considerations should be viewed as ultimately "procompetitive" and accorded

the same (or greater) weight as competitive factors in a Rule of Reason analysis.

Unlike insurers and other fee-paying organizatons, physicians are ethically and legally required to place their patients' health before economic considerations. Their primary concern must be for the health and well-being of their patients. Physicians and other health care providers deal with life and death issues; and strictly economic-based antitrust standards which have been developed in the context of cases involving the commercial/industrial sector should not be applied without modification to professional health care providers. When third-party payers adopt unreasonable cost containment practices that threaten patient well-being, or otherwise unreasonably intrude into the physician-patient relationship, courts must be able to weigh quality of care concerns in evaluating the legality of joint physician conduct undertaken in response. The alternative would chill physicians' properly motivated efforts to achieve and maintain high standards of care and would unreasonably compromise proper patient care.

The arguments advanced in the FTC brief can be read to urge the application of an unmodified standard to the collective activities of health care providers. This position poses a real threat to the quality of health care. Accordingly, PSAM submits that:

1. Ethical and quality of patient care concerns are vital inquiries in a Rule of Reason case involving the medical profession; and such patient care concerns must be given substantial weight regardless of whether they are characterized as "competitive" or "economic."

2. Physicians should be able to engage in certain collective activities vis-a-vis third-party payers if motivated by a genuine desire to promote the quality of health care or to advance or maintain ethical standards; and such physicians should not have to demonstrate that, in fact, their collective action was in response to adverse medical results in prior cases.

Argument.

I. When Collective Action by Physicians Is Challenged under the Rule of Reason, Ethical and Quality of Health Care Factors Must Be Entertained as Substantial Justifications.

A. *The Legal Issue.*

Quality of health care should be a significant factor in a non-price Rule of Reason[2] case involving health care professionals. Indeed, the FTC brief seems to concede in places that quality of care is a relevant factor.[3] On the other hand, other portions of the FTC brief are indefinite as to what weight (if any) the FTC would give to quality of care factors. Those portions imply that good medical care is relevant only if it produces a so-called "procompetitive" result.[4]

For example, the FTC brief cites *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978), for

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[2] Although the administrative law judge applied both *per se* and Rule of Reason standards, both the full Commission and the Court of Appeals analyzed the case under the Rule of Reason. Accordingly, the question whether the Rule of Reason should be applied here is not an issue. PSAM concurs in the wisdom of applying the Rule of Reason in cases involving the medical profession. This Court, as well as courts of appeal, has long recognized that the *per se* standard should not be hastily applied to the professions, in particular to the medical profession. *See United States* v. *Oregon State Medical Soc'y*, 343 U.S. 326, 336 (1952); *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d 1479, 1492 (D.C. Cir. 1984); *Wilk* v. *AMA*, 719 F.2d 207, 221 (7th Cir. 1983), *cert. denied* __ U.S. ___, 104 S.Ct. 2398 (1984); *Weiss* v. *York Hospital*, 745 F.2d 786, 821 n.61 (3d Cir. 1984), *cert. denied*, ___ U.S. ___, 105 S.Ct. 1777 (1985). *See also Goldfarb* v. *Virginia State Bar*, 421 U.S. 733, 788 n.77 (1975); *National Soc'y of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978).

[3] See, e.g., FTC brief at 38 n.30.

[4] FTC brief at 21.

the proposition that health care "quality" is a legitimate objective to be considered in a Rule of Reason case.[5] The FTC seems to acknowledge that a concern with quality on the part of consumers is one of the elements of the economic "bargain" and, "perforce", an element of competition.[6] To the extent that the FTC position deems quality of care goals to be procompetitive, PSAM has no quarrel with the FTC's position.

On the other hand, however, the FTC brief contains a number of assertions that dilute or vitiate the proposition that quality of health care is a legitimate, independent and forceful consideration in a Rule of Reason case. For example, the FTC criticizes the Court of Appeals' "implicit acceptance of IFD's asserted *noncompetitive justifications* for the boycott."[7] and argues that "ethical norms are relevant . . . *only insofar* as they 'serve to regulate and promote . . . competition.'"[8] Similarly, the FTC argues that once an anticompetitive impact is demonstrated, "[t]he only issue remaining . . . is whether the conspiracy had procompetitive benefits that somehow outweighed the injury to competition. . . ."[9] In another place, the FTC brief characterizes the "legal, moral, and ethical" factors as "asserted *noncompetitive justifications*."[10] Further, the FTC states that an unreasonable restraint of trade exists "absent a showing that the concert conducted itself generated *offsetting procompetitive effects*. . . ."[11]

[5] FTC brief at 27.

[6] FTC brief at 27.

[7] FTC brief at 21 (emphasis added).

[8] FTC brief at 21 (citing *Professional Engineers* 435 U.S. at 696) (emphasis added).

[9] FTC brief at 36.

[10] FTC brief at 37 (emphasis added).

[11] FTC brief at 21 (emphasis added).

Thus the FTC brief is disturbingly ambiguous. Whatever the reasons for the ambiguity,[12] its characterizations of ethical or quality concerns as "noncompetitive" (and, thus, apparently irrelevant) raises a profoundly important legal issue — the degree to which quality of health care factors will be weighed in a Rule of Reason analysis, and whether such factors are relevant where they do not produce measurable "procompetitive" consequences.[13]

As noted above, the principal case relied on by the FTC in support of its position is the Court's decision in *Professional Engineers*. The case is cited for the proposition that quality of health care factors are not relevant *unless* those factors promote competition.[14] PSAM does not believe that the decision in *Professional Engineers* should be applied in such a sweeping manner in a non-price case.

Professional Engineers involved what was tantamount to a horizontal price-fixing arrangement among competitors who argued that their "Code of Ethics was reasonable because competition among professional engineers was contrary to the public interest."[15] Not surprisingly, the Court rejected the petitioners' reliance on footnote 17 in *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), as "a frontal assault on the basic policy

[12] The ambiguity in the FTC brief may be attributable to the confusion that frequently results from resort to labels or shorthand expressions, such as "procompetitive", "noncompetitive", and "noneconomic" justifications. PSAM's major concern is not what label is applied to health care considerations. Rather, it is the confusion created in the FTC brief as to what weight (if any) is to be given to these considerations that compels PSAM to file this brief.

[13] Once again, if, as the FTC brief suggests in places, quality of health care is to be equated with procompetitive considerations (see, e.g., FTC brief at 21, 27, 38 n.30), PSAM does not take issue with the FTC's position. PSAM believes that quality of care concerns in the medical profession can be viewed as an element of competition, and therefore, as procompetitive.

[14] FTC brief at 21, 36, 38, 39.

[15] *Professional Engineers*, 435 U.S. at 684.

of the Sherman Act";[16] and the Court concluded that the Rule of Reason does not support a defense based on the assumption that "competition itself is unreasonable.[17] PSAM believes and respectfully submits that because *Professional Engineers* arose in the context of purely commercial activity and involved "an absolute ban on competitive bidding"[18] (price being "the 'central nervous system of the economy'"[19]) it should not be a basis for invalidating non-price collective action by health care professionals designed to promote or achieve non-economic quality of health care goals.[20]

While *Professional Engineers* can thus be distinguished, PSAM recognizes that the opinion does state that the inquiry in a Rule of Reason test "is confined to a consideration of impact on competitive conditions.[21] Indeed, it is the Court's focus on "economic conceptions"[22] on which the FTC now relies to support its position that quality factors are not relevant *unless* a demonstrable "procompetitive" result is produced.

The Court also, however, reaffirmed its adherence

> to the view expressed in *Goldfarb* that, by their nature, professional services may differ significantly

[16] Id. at 695.

[17] Id. at 696.

[18] Id. at 692.

[19] Id. at 692 (citing *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n.59 (1940)).

[20] Cf. Dissent of Justice White in *NCAA* v. *Board of Regents*, ___ U.S. ___, 82 L.Ed.2d 70, 104-105 (1984) where he observed that the Court's statements about the focus on competitive factors were made in the context of a case where public interest arguments were advanced in support of "a ban on competitive bidding imposed by practitioners engaged in standard profit motivated commercial activities".

[21] 435 U.S. at 690.

[22] Id. at 690 n.16.

> from other business services, and, accordingly, the nature of the competition in such services may vary. Ethical norms may serve to regulate and promote this competition and thus fall within the Rule of Reason.[23]

The Court's recognition of the unique nature of the professions, while at the same time apparently limiting the Rule of Reason inquiry to economic and competitive factors, has created uncertainty.

PSAM submits that in non-price cases involving the health care professions, rigid application of traditional, economic-based, antitrust concepts is inappropriate.[24] A rigid application of shorthand economic tests does not facilitate analysis of non-price health care cases. Quality of care factors must either be viewed as being substantially "procompetitive," or, preferably, as independently relevant factors to be accorded substantial weight in a Rule of Reason analysis. The labels "procompetitive" and "economic" are no more enlightening than the basic Rule of Reason standard of "reasonableness." They are merely shorthand descriptions, and should not be considered as the articulated standard governing non-price, quality-oriented collective action by health care professionals. Rather, PSAM submits that the analysis should be similar to that recent-

[23] Id. at 696.

[24] Such an analysis would not be consistent with prior decisions of this Court which acknowledge the need to consider a wide range of factors in antitrust claims against professionals. Indeed, consideration of noneconomic factors has been sanctioned by this Court in purely commercial contexts as well. See, e.g., *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 55 n.23 (1977) (product safety and product quality are legitimate considerations in analyzing restraints of trade). Cf. *Professional Engineers*, 435 U.S. at 695 (aspects of a commercial bargain affected by competition include not only immediate cost, but also quality, service, safety and durability).

ly suggested by Justice O'Connor — namely, one that weighs the restraint's anticompetitive impact against its positive health care benefits:

> Such an arrangement, that has little anticompetitive effect and achieves substantial benefits in the provision of care to patients, is hardly one that the antitrust law should condemn.[25]

In his concurring opinion in *Professional Engineers* (joined by Justice Rehnquist), Justice Blackmun expressed his concern over what he perceived as the Court's narrow shaping of the Rule of Reason:

> My skepticism about going further in this case by shaping the Rule of Reason to such a narrow last as does the majority, arises from the fact that there may be ethical rules which have a more than *de minimis* anticompetitive effect and yet are important in a profession's proper ordering.[26]

PSAM shares that concern and submits that the Court's decision in *Professional Engineers* should not be read to foreclose consideration of quality of health care justifications in nonprice Rule of Reason cases — regardless of whether such justifications qualify under the rubrics "procompetitive" or "economic."

There are compelling reasons why quality of health care factors — regardless of how they are labeled — should be ac-

[25] *Jefferson Parish Hospital* v. *Hyde*, ___ U.S. ___, 80 L.Ed.2d 2, 33 (1984).

[26] 435 U.S. at 700.

corded substantial weight. Unlike concerns which operate in the commercial/industrial sector of the economy, the professional concerns of physicians cannot be viewed as primarily economic.[27] The Hippocratic oath requires the physician to:

> follow that system of regimen which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.[28]

The American Medical Association's Principles of Medical Ethics require that patient welfare always be the physician's prime concern.[29] Indeed, physicians are ethically obligated to place the patient's welfare above "external consider-

[27] Obviously, the physician, like the industrialist, is motivated to some degree by economics, and PSAM does not suggest otherwise. But, unlike the industrialist, the physician's primary obligation is to the welfare of his or her patients — a concern which must take precedence over economic considerations. See, e.g., American Medical Association Principles of Medical Ethics, I ("A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity"); American College of Physicians Ethics Manual, Part I, 101 Annals Internal Med. No. 1, 129, 131 (1984) (physician's "duty to the patient and to society should take precedence over compensation in determining his actions; his highest commitment is to the patient") (hereinafter cited as "I-Ethics Manual"). See also F.H. Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. Legal Med. No. 2, 157 (1985).

[28] Hippocratic Oath, Taber's Cyclopedic Medical Dictionary, H-48, 49 (C.L. Thomas ed. 12th ed. 1973). Cf. K. Wrenn, M.D., *Sounding Board: No Insurance, No Admission*, 312 N. Eng. J. Med. No. 6, 373 (1985) (medical profession's primary purpose is providing service of health care; Hippocratic Oath requires principal focus on service, not economics). See also Declaration of Geneva, Taber's Cyclopedic Medical Dictionary, D-6, 7 ("The health of my patient will be my first consideration"); and Prayer of Maimonides, Taber's Cyclopedic Medical Dictionary, P-128.

[29] I-Ethics Manual at 130-132.

ations" such as "economic[s]."[30] Providers of health care may not consider economics in deciding whether to transfer a seriously ill or injured patient to another facility, and the patient's health must be the sole determining factor.[31] Indeed, in some jurisdictions, the law requires that patient welfare be placed before economic considerations.[32]

Additionally, many of the collective actions undertaken by the medical profession are not easily characterized as "procompetitive" or "economic", because they express values that are not readily susceptible of economic valuation. For example, concerted good faith action by physicians to compel the use of certain diagnostic tests which they as a group have found medically necessary in the treatment of certain conditions may not be viewed as economic or procompetitive in the short term, and would be difficult to value in the long term if effective in the prevention of disease. Indeed, the more effective the prevention, the more difficult to evaluate whether and to what extent disease would occur at all. Similarly, a medical association's unquestioned right to adopt standards of practice which result in restricting the number of physician competitors may not be viewed as producing a direct procompetitive result.[33]

PSAM submits that the medical profession's adherence to medical and ethical standards to assure the quality of health

[30] American College of Physicians Ethics Manual, II, 101 Annals Internal Med. No. 2, 263, 265 (1984) (hereinafter cited as "II-Ethics Manual").

[31] Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals at 23, 69 (1976) (no person should be denied access to treatment on the basis of "the nature of the source of payment"; patient may not be transferred from emergency room for arbitrary reasons).

[32] See, e.g., *Thompson* v. *Sun City Community Hospital, Inc.*, 141 Ariz. 597, 688 P.2d 605 (1984); *Guerrero* v. *Copper Queen Hospital*, 112 Ariz. 104, 537 P.2d 1329 (1975); *LeJuene Road Hospital, Inc.* v. *Watson*, 171 So.2d 202 (Fla. 1965).

[33] See concurring opinion of Justice Blackmun in *Professional Engineers*, 435 U.S. at 700-701.

care is both desirable and necessary; and the application of a solely economic-based Rule of Reason analysis without substantial regard for quality concerns will serve to undermine health care standards to the detriment of patients.[34]

Because the health care professions are different from commercial/industrial markets in these and other important respects, courts have been appropriately reluctant to apply traditional antitrust concepts without careful analysis:

> We might observe in passing, however, that there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.[35]

Indeed, this Court's unanimous decision in *Goldfarb* acknowledged that:

> [i]t would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas.[36]

Courts of appeals have exhibited the same reluctance.[37]

[34] PSAM acknowledges that there are cases where the application of traditional antitrust concepts is appropriate, such as horizontal price-fixing or division of markets. See, e.g., *Arizona* v. *Maricopa County Medical Soc'y*, 457 U.S. 332 (1982). PSAM is concerned primarily with the refusal to deal issue raised by this case.

[35] *United States* v. *Oregon State Medical Soc'y*, 343 U.S. at 336.

[36] *Goldfarb*, 421 U.S. at 788 n.17.

[37] See, e.g., *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d at 1492-1495; *Wilk* v. *AMA*, 719 F.2d at 223-231.

If it chooses to address this important legal issue, the Court should clarify its decision in *Professional Engineers* and either reject the broad assertion that *only* "procompetitive" or "economic" considerations should be entertained in non-price cases involving the medical profession, or make clear that quality of care considerations are deemed to be procompetitive.

B. *The Medical Issue.*

Recent developments in the health care industry make it imperative that collective action by health care professionals not be measured solely by economic standards. Health insurance companies, reacting to increased competition from health maintenance organization (HMO's), self-insuring employers, and other third-party payers, have implemented cost containment programs to protect their profitability.[38] A common cost containment strategy involves the imposition of restrictions by insurers and other fee-paying organizations whereby medical services are arbitrarily limited.[39] In this way insurers limit a patient's access to treatment, such as by controlling access to specialists, restricting the use of certain diagnostic tests, or limiting the number of hospital days permissible for a given treatment.[40] Indeed, insurers and other institutional providers frequently reserve to themselves the right to determine what is "medically necessary".[41] Not infrequently, the corporate de-

[38] See Alpert & McCarthy, Beyond *Goldfarb*: applying traditional antitrust analysis to changing health markets, 29 Antitrust Bull., No. 2 at 165, 173, 182 (1984).

[39] S.J. McPhee, L.P. Myers, B. Lo and G. Charles, *Cost Containment Confronts Physicians*, 100 Annals Internal Med. No. 4, 604 (1984).

[40] See N.R. Kleinfield, "When the Boss Becomes Your Doctor", N.Y. Times, Jan. 5, 1986, Business Section.

[41] See, e.g., Massachusetts Blue Cross/Blue Shield, *Master Health Plus Subscribers Certificate* at 29 (1985):

> B. How We Determine What Is Medically Necessary — The fact that your physician or some other provider has furnished, prescribed, ordered, recommended, or approved a service does not of itself make the service medically necessary. That determination will be made by us based on a review of the medical records describing your condition and treatment.
>
> C. Payment For Services Which Are Not Medically Necessary — If you receive a service which is otherwise covered as a Blue Cross and Blue Shield benefit under this contract, but which is not medically necessary for you, you might be charged for the service by the provider. We will defend you from a claim for payment for such a service in the following situations, unless you were told, knew or reasonably should have known, before you received the service, that it was not medically necessary.

termination of what is "medically necessary" is at variance with the attending physicians' analysis of the patient's needs.[42]

[42] See Kleinfeld, *supra*, n.40. Despite the seriousness of the conflict between established medical practices and cost containment, documented examples of actual experiences are, perhaps understandably, hard to find. PSAM's officers and members have many personal experiences of this conflict. The following anecdotal examples are accurate representations of actual cases in which PSAM physicians were personally involved:

Restriction on hospital admission.

A patient required surgery to remove cataracts that were interfering with her vision in both eyes. The patient's insurer requires all cataract surgery to be performed on an outpatient basis and prohibits any admission to a hospital in connection with such surgery. After cataract surgery a convalescing patient must keep the eye patched and requires periodic application of eye drops. In this instance the patient was elderly and in frail health, lived alone, suffered from diabetes, and which required regular injections of insulin. Because the patient would be temporarily blind after surgery, unable to care for herself, and highly prone to accidental falls if left unattended, the treating physicians asked the insurance company's permission to hospitalize the patient for cataract surgery and for several postoperative days. The insurance company's non-physician reviewer refused to approve this treatment. The attending physicians protested strongly and, only after seven weeks of continual pressure, secured permission to hospitalize the patient for a single night. During this seven week period the patient was unable to see. After the operation the patient remained at home unattended. The patient eventually recovered.

Restriction on use of diagnostic test.

A 38-year old patient sought emergency treatment in a hospital emergency room, complaining of paralysis in both arms and legs, slurred speech, and a

This occurs when the insurance company, customarily relying on actuarial statistics,[43] has predetermined that a physician's recommended treatment for a patient with a particular medical condition is not medically necessary. In such situations, purely economic considerations, based on statistical analysis, can dictate whether a particular patient will receive the treatment deemed medically necessary by the physician, regardless of whether the patient's needs conform to actuarial norms. In this

severe headache. The patient had recently been taking muscle relaxant pills to reduce neck pain, and on that evening had consumed several cans of beer. Upon examination, the patient's brain appeared to be swollen and brain matter was attempting to herniate through the foramen magnum (a hole at the base of the skull). The attending physicians, including an anesthesiologist trained in the specialty, determined that the patient would die if the pressure on his brain were not relieved immediately. The health maintenance organization that was the patient's insurer, without having seen the patient, insisted that the problem was merely an adverse drug reaction and that the patient should be sent home. The insurer refused to authorize a diagnostic test on a computer tomography scanner (CT scan) which would indicate abnormalities in the brain. Because of its clear medical necessity, the anesthesiologist nevertheless ordered the CT scan. Because of the delay occasioned in dealing with the insurer this required bringing in the hospital's radiologist late at night. In the meantime, the patient had been given medication to reduce swelling before rapidly becoming comatose, a condition which further required insertion of an intubate tube into the trachea to permit him to breathe. The patient later recovered consciousness. The CT scan showed a brain abnormality in the posterior fossa at the back of the skull. The insurer continued to insist that the problem was simple drug reaction, although it never examined the patient. A computer search in the National Index Medicus showed no indication of such a reaction between the drug taken and alcohol — a finding confirmed by the drug manufacturer, which had no prior complaint or indication of such a reaction. The case received attention in the press because of the patient's position as a college football coach. After the matter was publicized, the insurer authorized payment for the CT scan and subsequent treatment by the anesthesiologist.

[43] Cf. Blue Shield of Massachusetts, Inc., *Methods of Reimbursement*, Reference Manual For Participating Physicians, Dentists and Other Blue Shield Providers, § 4; P. Starr, *The Social Transformation of American Medicine*, 329-330 (1982).

respect, insurance companies' insistence on the primacy of economic concerns can intrude unreasonably in the physician-patient relationship, and usurp the professional judgment of health care professionals regarding the type and amount of treatment.[44] When divorced from medical and ethical norms, such cost containment policies pose a serious ethical and legal dilemma to treating physicians and threaten to lower the quality of health care by elevating economic considerations above patient welfare.[45]

Physicians are held to collectively devised standards of practice, and have a collective professional responsibility[46] to ensure that those standards are adhered to by for-profit organizations that presume to decide the medical necessity of tests and treatments based on actuarial models. An individual physician is commonly helpless to protest effectively the actions of a

[44] The FTC brief contains the somewhat naive assertion that the insurance company does not dictate the course of treatment but only determines whether coverage is available. FTC brief at 40. In fact, however, the insurance companies' refusal to pay does effectively dictate treatment particularly in a state such as Massachusetts where ban on balance billing legislation (G.L. c. 176B, § 7) prohibits physicians from charging patients for the cost of treatment in excess of the amount deemed appropriate by the insurer for covered services. The practical result is that the patient must often do without the treatment not compensated by the insurer, even where deemed medically necessary by the physician. See A. Stone, M.D., *Sounding Board: Law's Influence on Medicine and Medical Ethics*, 312 New Eng. J. Med. No. 5, 309, 312 (1985) (cost control efforts create a "potential conflict of interest between patient and physician"); F. Moore, *Who Should Profit From the Care of Your Illness?*, Harvard Mag. 45, 47, 49-52 (Nov.-Dec. 1985).

[45] D. Mechanic, *Sounding Board: Public Perceptions of Medicine*, 312 New Eng. J. Med. No. 3, 181, 182 (1985) (cost control efforts contribute to tensions between doctor and patient by transforming focus from advocacy for patient to concern with cost-effectiveness); J.A. Marsh, *supra*, at 157; McPhee, *supra*, at 604; N.G. Levinsky, M.D., *The Doctor's Master*, 311 N. Eng. J. Med. No. 24, 1573 (1984).

[46] See nn.27-32, *supra*, and accompanying text; I-Ethics Manual; II Ethics Manual; F.H. Marsh, *supra*.

large third-party payer on which he is economically dependent. As the health care field becomes more commercialized, and as physicians are subject to increased supervision by for-profit enterprises with strong incentives to cut costs, the economic pressure on the individual physician to conform to the directives of such organizations rather than to patient needs will predictably increase.[47] For example, the standard form contract between individual participating physicians and Blue Shield of Massachusetts, Inc., requires the physician to abide by the by-laws and rules and regulations adopted by Massachusetts Blue Shield, Inc.[48] A physician who deviates from the procedures and standards established by the insurer may face termination of his or her contract and the consequent loss of access to approximately 74 percent of the private Massachusetts medical market.[49] Accordingly, where patient concerns are significant, physicians must be free to engage in collective action[50] to induce institutional providers to cover services deemed medically necessary to be in good faith, particularly where anticompetitive results are incidental, insubstantial or unproved.[51]

[47] P. Starr, *supra*, at 444-449; D. Mechanic, *supra*, at 182.

[48] Blue Shield of Massachusetts, Inc., *Application of and Agreement With Participating Physicians*; Blue Shield of Massachusetts, Inc., *By-Laws and Rules and Regulations*, Reference Manual, *supra*, §§ 1 & 2.

[49] *Id.* See *Kartell* v. *Blue Shield of Massachusetts, Inc.*, 749 F.2d 922, 924 (1st Cir. 1984), *cert. denied*, ___ U.S. ___, 105 S.Ct. 2040 (1985).

[50] PSAM notes the irony presented by the FTC's position. While acknowledging that insurers, unions and employers *collectively* insist on such cost containment measures (FTC brief at 19), the FTC challenges the dentists' collective resistance to cost containment procedures. The FTC's position is even more ironic when one recognizes that the insurance company-employer union collective was economically motivated, while the dentists (as found by the Court of Appeals) were motivated by legal, ethical and moral considerations.

[51] The FTC brief incorrectly assumes that *any* cost containment effort necessarily enhances consumer welfare (FTC brief at 25). Ironically, however, the FTC itself concedes that the particular cost containment program in the present case did not have any demonstrable impact on cost. FTC brief at 35 n. 28. PSAM acknowledges, and, indeed, enthusiastically supports efforts to curtail the increasing cost of quality medical care; and it does not oppose all cost containment efforts. PSAM is vitally concerned, however, that the preoccupation of "cost containment" with economics not supplant the physician's judgments concerning what treatments are medically necessary or deprive patients of needed care.

To interpret the antitrust laws to deny patients the benefit of collective action by health care providers against cost containment practices which are antithetical to patient welfare is to place economic concerns before good health care, patient welfare, and perhaps life itself.

II. Physicians Should Be Able to Engage in Collective Action if Motivated by a Genuine and Reasonable Desire to Promote Quality of Health Care; and in Response to an Antitrust Challenge Physicians Should Not Be Required to Demonstrate that the Collective Action Was in Response to Adverse Medical Results in Prior Cases.

The FTC brief contains a disturbing criticism of the Court of Appeals' decision:

> Implicit in the court's opinion is its apparent view that the mere assertion of justifications unrelated to the competitive effect of a challenged restraint should weigh heavily in cases concerning conspiracies by professionals to subvert competition.[52]

When this passage is read with an assertion contained on the preceding page of the FTC brief, another important issue is framed:

> The Commission rejected these contentions [IFD assertion of quality of dental care justification], finding no evidence that any consumer received substandard dental care or suffered any injury as a result of insurer examination of x-rays.[53]

[52] FTC brief at 37.

[53] FTC brief at 36.

The FTC appears to be advocating a Rule of Reason standard that would ignore evidence of physicians' good faith and reasonable belief that collective action was required to ensure quality medical care. The FTC would instead insist on evidence of actual harm or substandard care before collective action could be justified.[54] The FTC standard, literally applied, would require a "body count" before health care professionals would be permitted to assert collectively devised standards of treatment and care.

The adoption of such a harsh standard would pose a serious risk to patient welfare and would profoundly discourage any collective endeavor of physician groups to pressure for institutional changes in the quality of health care delivery. The medical standards applied to physicians are devised through predictive scientific processes that are intended to prevent the very demonstration of harms envisioned by the FTC. Under such a standard, physicians would be left with the legal and moral responsibility for furnishing the highest quality of care, but would no longer have the ability to shape and uphold the standards they are required to follow. Physicians would be forced from their proper role as advocates for their patients to become the mere instruments of insurers. The long-term interests of patients, especially those who lack the means to supplement the provisions of their insurance coverage, will almost surely be injured.

The antitrust laws should not be construed to require concerned health care professionals who recognize a potential threat to quality health care to await actual injury or the provision of demonstrably substandard care before raising a pro-

[54] Indeed, the Brief of the Health Insurance Association of American as Amicus Curiae ("HIAA brief") advocates the same standard: "There is no indication that the cost containment efforts requiring access to dental x-rays had any adverse effects on patient health or the quality of care received." HIAA brief at 19.

test. Instead, PSAM urges that physicians and other health care providers be permitted to justify challenged collective action on non-price issues by demonstrating that their primary motivation was the attainment or preservation of medical and ethical standards, that they had a reasonable basis for their belief, and that their action was taken in good faith and was reasonably necessary to attain that goal.[55] Where patients' health and lives are at stake, the antitrust laws should not be applied to prevent physicians and other medical providers from taking prudent collective action to prevent predictable harms and to uphold the standards of their profession, even when the value of such activities cannot be readily measured in the currency of the marketplace.

Conclusion.

PSAM suggests to the Court that the weight to be accorded quality of care factors in a Rule of Reason analysis is a question best left for another day when the issue is directly presented and fully briefed.[56] However, if the Court chooses to address this issue or the ambiguities raised in the FTC brief, the Court should reject the FTC's suggestion that collective action by health care professionals which does not produce procompetitive consequences is irrelevant in a Rule of Reason case. Substantial weight should be given to quality of care factors in a

[55] Cf. *Graphic Products Distributors Inc.* v. *Itek Corp.*, 717 F.2d 1560, 1577 (11th Cir. 1983) (whether the restraint is "reasonably necessary" to accomplish a legitimate objective); *Kreuzer* v. *American Academy of Periodontology*, 735 F.2d at 1494 (whether justification is closely related to a lawful purpose).

[56] Cf. *White Motor Co.* v. *United States*, 372 U.S. 253 (1963) (postponing determination of whether *per se* or Rule of Reason standard was to be applied to legality of non-price vertical restrictions).

Rule of Reason analysis, independent of strictly economic or competitive considerations. Alternatively, the Court should acknowledge that quality of care concerns are to be equated with procompetitive concerns. Finally, physicians who act collectively in good faith to achieve or maintain health care quality should not be required to demonstrate that their collective action was in response to instances of harm to patients.

Respectfully submitted,

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